FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 12802

Registered No. .....

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

County of Kootenai

City of Spirit Lake (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Anna Spencer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. 1 (Month) 24 (Day) 1879 (Year)

7. AGE: 36 Yrs. 11 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Isaac Bailey

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER M. B. Hartsock

13. BIRTHPLACE OF MOTHER (State or Country) Orange Co N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac Bailey

(Address) Spirit Lake

15.

Filed 1/9 1916 C. Nauck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1915, to Jan 8 1916, that I last saw h[illegible] alive on Jan 7 1916, and that death occured on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Cancer of the duodenum
(Carcinoma)
(Post mortem Ex. made)

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ... yrs) ... mos. ... ds.

(Signed) Early D. Brindley M. D.

1-9 1916 (Address) Spirit Lake

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spirit Lake — DATE OF BURIAL: 1/9 1916

20. UNDERTAKER: C. M. Stone — ADDRESS: Rushmore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ROBS. 24854

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 12803
Registered No.

1. PLACE OF DEATH.
County of
City of
Registration District No.
Primary Registration District No.
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Eftedal

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 19 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spirit Lake Ida

10. NAME OF FATHER: Marcus Eftedal

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Linga Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed 1/21 1916 C. Nacrich
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1916, to Jan 20 1916
that I last saw h[illegible] alive on Jan 20 1916
and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Infantile Convulsions

(Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) Congenital malformation of cleft palate & double hare lip
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Carl D Prindle M. D.
Jan 21 1916 (Address) Spirit Lake

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spirit Lake
DATE OF BURIAL: 1/21 1916

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 5-5

County of Bear Lake Primary Registration District No.

City of near St Charles (or) ..... St.)

File No. 12805

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David W Oakey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 18 (Day) 1886 (Year)

7. AGE: 30 yrs. 6 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Paris, Bear Lake Idaho

10. NAME OF FATHER: Charles Oakey

11. BIRTHPLACE OF FATHER (State or Country): Worcestershire Eng

12. MAIDEN NAME OF MOTHER: Mary Ann Passey

13. BIRTHPLACE OF MOTHER (State or Country): Worcestershire England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Will Oakey
(Address) Paris

15. Filed Jan 24 1916 John Mattson, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191..., that I last saw h... alive on ——— 191..., and that death occurred on the date stated above, at ——— M.

The CAUSE OF DEATH* was as follows:

Cause to Sure death
by drowning in the Canal
Belonging to Bear Lake Canal and
Co Ltd (Duration) Co yrs. mos. ds.
Contributory Engaging in a pastime
(Secondary) Co Ltd &
(Duration) yrs. mos. ds.

(Signed) Geo F Ashby Coroner M. D.
Jan 17 1916 (Address) Bancroft Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris — DATE OF BURIAL: Jan 17th 1916

20. UNDERTAKER: Geo Ashby — ADDRESS: Paris B L

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 12957

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. .....

Primary Registration District No. .....

1. PLACE OF DEATH.

County of Ada

City of Eagle (No. 8 Miles N. of Eagle St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME C. A. Crane

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) 8 (Day) 44 (Year) 1843

7. AGE: 72 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Arthur L Crane

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Calista J Crane

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas Elliot Crane
(Address) Eagle Ida

15. Filed Jan 5th 1916. L B Hoerle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Jan (Day) 4th 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1916, to Jan 3d 1916, that I last saw he alive on Jan 3d 1916, and that death occured on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jos. R. Newman M. D.

Jan 6 1916. (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery | DATE OF BURIAL: 1/4 1915

20. UNDERTAKER: Schreiber & Siddenfaden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of IDAHO BOARD OF HEALTH Bureau of VITAL STATISTICS

PLACE OF DEATH.

Registration District No. 11 12958

Primary Registration District No. 2003.

File No. 12958

Registered No. .....

County of Ada.

City of Near Meridian (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give NAME instead of street and number.

2. FULL NAME Jesse B. Flack.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
M	W.	Married

6. DATE OF BIRTH: Oct (Month) 5 (Day) 1880 (Year)

7. AGE: 35 yrs. 3 mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Indiana.

10. NAME OF FATHER: Fernando Damon.

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Helen Murphy.

13. BIRTHPLACE OF MOTHER (State or Country): Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Helen Brown
(Address) Meridian Ada

15. Filed Jan 7th 1915 C. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 6th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28th 1915, to Jan 6th 1916, that I last saw her alive on Jan 6— 1916 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Childbirth - Nephritis existed - Suppression of urine
Puerperal Eclampsia —
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory Chronic Nephritis
(Secondary)
(Duration) 1 yr. Several mos. — ds.

(Signed) C. L. Dutton M. D.
19 (Address) Meridian Ada

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
To Morris Hill Cem	1-7- 1916

20. UNDERTAKER	ADDRESS
Fry & Summers	Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. If LESS than 1 day, HOURS or MINUTES should be given. CAUSE OF DEATH should be stated in plain terms, so that it may be properly classified. CLERICAL ERRORS and OMISSIONS in the statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 12967

Registered No. 34

1. PLACE OF DEATH.
County of Bear Lake,
City of Bloomington (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 53
Primary Registration District No. 2152

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Ball

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W.	Married

6. DATE OF BIRTH
April (Month) 24 (Day) 1832 (Year)

7. AGE
83 yrs. 9 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or datablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Peter Ball

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Lucy Gullings

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Brinca
(Address) Bloomington

15.
Filed 1-8-1916 R. D. Sudbo
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 10 43 M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease
Death without medical attendance
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. D. Sutton M. D.
Jan 7 1916 (Address) Paris

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bloomington	Jan 9 1916

20. UNDERTAKER James Jacobson ADDRESS Bloomington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

U. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Ida[illegible]
BOARD OF HE[illegible]
Bureau of Vital S[illegible]

PLACE OF DEATH.

County of Bannock
City of Downey
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 111
Primary Registration District No. 2046
(No. ....., ... St.)

File No. 12979
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jane Elizabeth Byington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: May 28 1864 (Month) (Day) (Year)

7. AGE: 52 yrs. 7 mos. 4 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thurston Larson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Elizabeth Mary Fox

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L E Byington
(Address) Downey

15. Filed Jan 16 1916 Ellis Kelley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 1 (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1914, to Jan 1 1916, that I last saw h[illegible] alive on Jan 1 1916, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) Chronic Interstitial Nephritis Hypertrophy of Left Ventricle

(Duration) 1 yrs. 6 mos. ..... ds.

(Signed) Casper W Taylor M. D.
Jan 5 1916. (Address) Downey, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Calvin — DATE OF BURIAL: Jan 5 1916

20. UNDERTAKER: C E Taylor — ADDRESS: Downey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 49

Primary Registration District No. 2158

File No. 13017

County of Idaho

City of Jamiah (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christine Crowe.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Donald Henderson.

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Kate Douglas

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): .....

(Address): Geo V Crowe

15.

Filed Jan. 7th. 1916 W. J. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4th 1915., to Above 1916, that I last saw her alive on 1/5 1916, and that death occurred on the date stated above, at 1/5 M.

The CAUSE OF DEATH* was as follows:

Pneumonia Fever

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Brayton M. D.

1/6 1916 (Address) Kaniah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Willow Hill Cemetry — DATE OF BURIAL: Jan. 8th 1916

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kaniah Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lewis
City of Kamiah (or County)

Registration District No. 419
Primary Registration District No. 2128
(No. ....., ... St.)

File No. 13018
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Genette B. Hastings

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 4 (Month) 2 (Day) 1905 (Year)

7. AGE: 10 yrs. 9 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Part of a Child
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho Co. Idaho.

10. NAME OF FATHER: Malon L. Hastings

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Myrtle L. Murphy

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. L. Hastings
(Address) Kamiah, Idaho.

15.
Filed Jan 7th 1916
W. F. McMahan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916, to Jan 7 1916 that I last saw her alive on 1/7/1916 and that death occurred on the date stated above, at 3:00 M.

The CAUSE OF DEATH* was as follows:

Diphtheria

..... (Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) Influenza

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. D. Bryan M. D.

1/7 1916 (Address) Kamiah Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I. O. O. F. Cemetry
DATE OF BURIAL: Jan. 7th. 1916

20. UNDERTAKER: C. J. Johnson
ADDRESS: Kamiah.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13019
Registered No.

1. PLACE OF DEATH. Registration District No. 49
County of Idaho Primary Registration District No. 2128
City of Harrisburg Ida No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Eli Jook

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH: Nov. (Month) 10 (Day) 1846 (Year)
7. AGE: 70 yrs. 1 mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Penn.
10. NAME OF FATHER: Jacob. Jook
11. BIRTHPLACE OF FATHER (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Rebecca Hartzler
13. BIRTHPLACE OF MOTHER (State or Country): Penn.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C C Harvey
(Address) Harrisburg
15.
Filed 1/9/1916 W. F. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 8 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 7th 1916, to ahense 1916
that I last saw him alive on Jan 7th 1916
and that death occurred on the date stated above, at 11 a. M.
The CAUSE OF DEATH* was as follows:
Pneumonia fever
..... (Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. H. Bryan M. D.
1/8 1916 (Address) McGannon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodland — DATE OF BURIAL: 1/9 1916
20. UNDERTAKER: C. J. Johnson — ADDRESS: Harrisburg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon
City of Caldwell Rural

Registration District No. 3
Primary Registration District No. 2005
(No. ....., ... St.)

File No. 13206
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Burger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. August 9 (Month) (Day) 1845 (Year)

7. AGE: 70 Yrs. 4 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) ✓ ✓

12. MAIDEN NAME OF MOTHER ✓ ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓ ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) B R Johnson
(Address) Caldwell

15. Filed Jan. 4th 1916 — John C. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1915, to Jan 3rd 1916, that I last saw h. m. alive on Dec 12 1915 and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Asthma - Nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

1/4 1916 (Signed) T. J. Farmer M. D. (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverside Cemetery — DATE OF BURIAL: 1/5 1916

20. UNDERTAKER: W. C. Dyer — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRON - YORK CO., PTRS. & BNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 13207
Registered No. 2

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Shafer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April 21 1845
(Month) (Day) (Year)

7. AGE: 70 Yrs. 8 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Forest City Iowa.

10. NAME OF FATHER: Barker

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Hewett Dawson

13. BIRTHPLACE OF MOTHER (State or Country): Do not Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. E. Shafer
(Address) Nampa #4 Ida.

15. Filed 1-7-1916 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 5 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1915, to Jan 5 1916, that I last saw h alive on Jan 4 1916, and that death occured on the date stated above, at 11.45 a M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) Several Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
1/6 1916 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days
In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 1/7 1916

20. UNDERTAKER: O. C. Dyer
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BKBS. 24852

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

(No. ....., ... St.)

File No. 13208

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lewis Lamont Allen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): ~~Single~~

6. DATE OF BIRTH. Jan (Month) 8 (Day) 1895 (Year)

7. AGE: 20 Yrs. 11 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Labor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Wm Henry Allen

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Laura Estella Betterton

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Effie L Ross
(Address) Caldwell Idaho.

15. Filed 1-7-1916 John P. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1915, to Jan 5 1916, that I last saw him alive on Jan 5 1916 and that death occured on the date stated above, at 10.45 A.M.

The CAUSE OF DEATH* was as follows: Sarcoma of ~~testicle~~ testicle with metastasis in brain and 2nd Lumbar.

(Duration) Yrs. 3 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. Miller M. D.

1-6 1916 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 1-7-1916

20. UNDERTAKER: W. G. Dyer — ADDRESS: Caldwell

SYMS - YORK CO., PTRS. & BDRS. 24858

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee
City of Castonia
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3
Primary Registration District No. 2005
(No. ....., ... St.)

File No. 13209
Registered No. 4
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Michael Glare

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower

6. DATE OF BIRTH: Mar (Month) 7 (Day) 1837 (Year)

7. AGE: 78 yrs. 9 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cabinet maker
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Truman Glare

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Mary Harman

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Nora Faulder
(Address) Caldwell (Castonia) Ida

15. Filed 1-7-1916 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1915, to Jan 6 1916 that I last saw h/m alive on Jan 1 1916, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Diabetes -
..... (Duration) Chronic yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Lamm M. D.
Jan 7 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill Cem — DATE OF BURIAL: Jan 8 1916

20. UNDERTAKER: Peckham Co — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Registration District No. 1

County of Canyon — Primary Registration District No. 1006 — File No.

City of Nampa (No. ....., ... St.) — Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Missouri Ann Greenlee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 9 (Day) 1850 (Year)

7. AGE: 65 Yrs. 5 Mos. 22 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Mordica Hall

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H B Greenlee
(Address) Nampa Ida.

15. Filed Feb 2 1916 — Dr D Coburn, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-27 1916, to 1-31 1916, that I last saw her alive on 1-31 1916, and that death occured on the date stated above, at 5-35 PM.

The CAUSE OF DEATH* was as follows:

Malarial Infection

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pernicious Malaria comatose form

(Duration ..... yrs. ..... mos. 5 ds.

(Signed) H C Robinson M. D.

2-1 1916 (Address) 1317 4th St. So. Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 2-2 1916

20. UNDERTAKER: Dr D Coburn — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRD - YORK CO., BOISE, IDAHO

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 2006
File No. 13225
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Hilty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH.
May (Month) 17 (Day) 1843 (Year)

7. AGE
72 Yrs. 8 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER David Jno. Thut

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Jennie Bechtel

13. BIRTHPLACE OF MOTHER (State or Country) Ohio Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Louis Hilty.
(Address) .....

15. Filed Jan 22 1916 Wm D Calder Local Registrar
Louis Hatfield Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 1915, to Jany 21 1916, that I last saw her alive on Jany 21 1916, and that death occured on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) Yrs. 2 mos. 21 ds.
Contributory (Secondary) Hard asthma & more heart trouble
(Duration) yrs. mos. ds.
(Signed) J H Murray M. D.
Jan 22 1916 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mennonite Cemetery	1-23 1916
UNDERTAKER	ADDRESS
Fred Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRON - YORK CO., PRINT. & ENGR. OMAHA

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13226

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Nampa

(No. ....., ... St.)

Registration District No. .....

Primary Registration District No. 1006

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Wesley Bame

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 3 (Day) 1914 (Year)

7. AGE: 2 Yrs. ..... Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nampa Ida

10. NAME OF FATHER: Wesley Bame

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Cora E McKee

13. BIRTHPLACE OF MOTHER (State or Country): Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wesley Bame

(Address) Nampa Ida

15. Filed Jan 12 1916 Dirk DeBoer Local Registrar

Anna Hartsell Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9th 1916, to June 12 1916, that I last saw him alive on June 12 1916, and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Heart insufficiency
from birth

(Duration) 2 Yrs. mos. 9 ds.

Contributory (Secondary) —

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J H Murray M. D.

Jan 12 1916 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? —

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 1-13 1916

20. UNDERTAKER: Fred Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & STNRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 13227
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alley Anna Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 19 (Day) 1866 (Year)

7. AGE: 49 Yrs. 1 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Don't know

10. NAME OF FATHER: Don't know

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: Emma Holman

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. E. Fern Wright
(Address) Nampa Ida

15. Filed Jan 10 1916 W. P. Calonge Local Registrar
Anna Barfield Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1915 to Jan 8 1916, that I last saw her alive on Jan 8 1916, and that death occured on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Liver
(Duration) Yrs. 3 mos. ..... ds.
Contributory (Secondary) Carcinoma of uterus
(Duration ..... yrs. 6 mos. ..... ds.
(Signed) W. H. Ross M. D.
1/10 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 1-11 1916

20. UNDERTAKER: Funk Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS., DENVER

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Bowmont
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 2006.
(No. ....., ... St.)

File No. 13228
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Irving A. Bassett.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH
Jan. (Month) 22 (Day) 1844 (Year)

7. AGE
72 yrs. 0 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Instructor Pub. school,
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Michigan,

10. NAME OF FATHER Jno. Bassett,

11. BIRTHPLACE OF FATHER (State or Country) Not Known,

12. MAIDEN NAME OF MOTHER Not Known,

13. BIRTHPLACE OF MOTHER (State or Country) Not Known,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. B. Shellabarger,
(Address) Nampa Ida,

15.
Filed Jan 28 1916 Dr. D. Calder
Anna Hatfield Local Registrar
L. B. Shellabarger.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan. (Month) 27th (Day) 1916 (Year),

17. I HEREBY CERTIFY, ~~That I attended deceased from~~ ..... 191..., to ..... 191...,
~~that I last saw h~~ alive on ..... 191...,
~~and that death occurred on the date stated above, at ..... M.~~

The CAUSE OF DEATH* was as follows:
Acute dilitation of heart,
.....
Instantaneous,
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Not Known. Had never seen deceased until after death,
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. D. Calder M. D.
1/28/1916, (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida, Kohler Sem. DATE OF BURIAL: 1/29/1916

20. UNDERTAKER: L. B. Shellabarger. ADDRESS: Nampa Ida,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon
City of Nampa
(No. ..... St.)

Registration District No. 7
Primary Registration District No. 1006.

File No. 13229
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Michael Jordan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. March – uncertain 1838
(Month) (Day) (Year)

7. AGE: 84 Yrs. 11 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer Road Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): (retired 5 yrs).

9. BIRTHPLACE (State or Country): Killalla, Co. Mayo, Ireland.

10. NAME OF FATHER: Michael Jordan

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Annie B. Jordan
(Address) Nampa, Idaho.

15. Filed Feb 3 1916 Dr D Calong -Local Registrar
Nampa Garfield Depot Police

SYMS - YORK CO., PTRS. & STRS. 24655

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb 2 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1915, to Feb 2 1916, that I last saw him alive on Jan 31 1916, and that death occured on the date stated above, at 6 a M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease. Arterial Sclerosis

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Chronic Bright's Disease
(Duration yrs. mos. ds.

(Signed) Clyde Watson M. D.
Feb 2 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Catholic Cem.
DATE OF BURIAL: 2-4 1916

20. UNDERTAKER
ADDRESS: Nampa

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2007
File No. 13232
Registered No. 2

1. PLACE OF DEATH.
County of Canyon
City of Parma
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George B. Rowan

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	W	Div (Write the word.) Single

6. DATE OF BIRTH: Oct. (Month) 17 (Day) 1861 (Year)

7. AGE: 55 yrs. 4 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: David Rowan

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. A. Bates
(Address) Parma, Idaho

15. Filed Jan 17 1914 W. Muldoon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to Jan. 15 1914, that I last saw him alive on Jan. 15 1914, and that death occurred on the date stated above, at 6-30 P.M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) 2 yrs. 1 mos. 15 ds.

Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.

(Signed) W. E. Muldoon M. D.
Jan 17 1914 (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~	DATE OF BURIAL
Parma, Idaho	Jan. 17 1914

20. UNDERTAKER	ADDRESS
Peckham Bros	Parma, Idaho

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 36

Primary Registration District No. .....

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13234

Registered No. 19

1. PLACE OF DEATH

County of Twin Falls

City of .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marian B. Wilkson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: November 17 1896
(Month) (Day) (Year)

7. AGE: 19 Yrs. 2 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oklahoma

10. NAME OF FATHER: S. M. Barnes

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Josie D. Alderman

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): James L Barnes
(Address): Hansen

15. Filed Jan 29 1916 J. M. Davis
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 21st 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1916, to Jan 21 1916, that I last saw her alive on Jan 21 1916, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

Lobar

(Duration) ..... Yrs. ..... mos. 00 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Lundquist M. D.

19..... (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls DATE OF BURIAL: Jan 23 1916

20. UNDERTAKER: C J Crosby ADDRESS: Twin Falls

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 13234

Name Marian B. Willson

Date of Death January 21st, 1916

Cause of Death Lobar Pneumonia

Contributary Cause of death &&vv----

(Sign here) H. W. Lounsbold M.D.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13236
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Burke

Registration District No. 39
Primary Registration District No. 3087
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rhoda E. Farlow

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Dec (Month) 30 (Day) 1846 (Year)

7. AGE: 69 yrs. mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Thos McIntosh

11. BIRTHPLACE OF FATHER (State or Country) Ind

12. MAIDEN NAME OF MOTHER Jane Hayden

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel Farlow
(Address) .....

15.
Filed 1-4 1916
J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw her alive on Jan 3rd 1916
and that death occurred on the date stated above, at about 6 A M.

The CAUSE OF DEATH* was as follows:
acute dilatation of heart

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Wellington M. D.
1-3 1916 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burke
DATE OF BURIAL: Jan 6 1916

20. UNDERTAKER: C. J. Grossman
ADDRESS: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 13237
Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls
City of Burley
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dan Keohane

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan (Month) 11 (Day) 1916. (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Coal miner
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Coal Creek

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H S Evans
(Address) Deputy Coroner Burley Ida

15.
Filed 1-12 1916
J. H. Mumley
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Death was instantaneous & was due to acute dilitation of heart
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) A. J. McClusky M. D.
1/11 1916 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF [illegible] OR REMOVAL Salt Lake
DATE OF BURIAL .....191...

20. UNDERTAKER Homer B. Evans
ADDRESS Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 13238
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Burke Ida.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clyde Mason

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 20 (Day) 1910 (Year)

7. AGE: 5 Yrs. 5 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burke Ida

10. NAME OF FATHER: W. F Mason.

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Alta Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. F. Mason
(Address) Burke Ida

15.
Filed 1-17 1916
J. N. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 29 1915, to Jan 16 1916, that I last saw h in alive on Jan 15 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Dyspepsia
(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Acute nephritis
(Duration) ..... yrs. 1 mos. ..... ds.
(Signed) Chas. W. Wallace M. D.
1-16 1916 (Address) Burke Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burke Ida — DATE OF BURIAL: Jan 18 1916

20. UNDERTAKER: Homer B Evans — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Cambridge
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 88
Primary Registration District No. 2164
(No. ....., ... St.)

File No. 13239
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ellen Grummett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 26 (Day) 1875 (Year)

7. AGE: 40 yrs. 6 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: John Bureau

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Elizabeth

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Grummett
(Address) Indian Valley Ida.

15. Filed Feb 1 1916. O E Schmuck Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1916., to Jan 21 1916, that I last saw her alive on Jan 21 1916, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Pyo Thorax

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia Chronic
(Duration) ..... yrs. 1 mos. 1 ds.

(Signed) Simeon Hopkins M. D.
1-21- 1916 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 88

Primary Registration District No. 2164

File No. 13240

County of Washington

City of Cambridge (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Thompson Adams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH

May (Month) 12 (Day) 1837 (Year)

7. AGE

78 yrs. 8 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Thompson

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Margaret Knowner

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Francis Adams

(Address) Cambridge Ida

15. Filed Feb 1 1916 O E Schuyler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916., to Jan 14 1916, that I last saw her alive on Jan 14 1916, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular

(Duration) ..... yrs. ..... mos. 14 ds.

Contributory Exhaustion & Cold.
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O E Schuyler M. D.

Jan 16 1916 (Address) Cambridge Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Salubria Ida. DATE OF BURIAL Jan 16 1916

20. UNDERTAKER Jas Hamilton ADDRESS Cambridge Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 88

County of Washington

Primary Registration District No. 2164

City of Cambridge (No. ....., ... St.)

File No. 13241

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac Rambo

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

Dec (Month) 9 (Day) 1836 (Year)

7. AGE

80 yrs. 1 mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Farmer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Isaac Rambo

11. BIRTHPLACE OF FATHER (State or Country) .....

12. MAIDEN NAME OF MOTHER Elizabeth Tingler

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sylvia Ward

(Address) Council Ida

15. Filed Feb 1 1916 O E Schmutz Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1916., to June 24 1916, that I last saw him alive on June 24 1916, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Paralysis of Right Side

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Old age and exposure

(Duration) ..... yrs. ..... mos. 12 ds.

(Signed) O E Schmutz M. D.

Feb 1 - 2 1916 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida — DATE OF BURIAL: Jan 26 1916

20. UNDERTAKER: J A Anderson — ADDRESS: Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 1050

File No. 13242

County of .....

City of .....

(No. ....., ... St.)

Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant of J. Haldson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec. 21 (Month) Dec 20 days (Day) 1915 (Year)

7. AGE ..... Yrs. ..... Mos. 11 ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... —

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) 311 Park drive

10. NAME OF FATHER J. Haldson.

11. BIRTHPLACE OF FATHER (State or Country) Wis.

12. MAIDEN NAME OF MOTHER Lena Dorothea

13. BIRTHPLACE OF MOTHER (State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Jan. 4 1916 M. E. Robuck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1915, to Jan 1 1916, that I last saw h[illegible] alive on Dec 31 1915 and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Malnutrition

.....(Duration) 0 Yrs. 0 mos. 11 ds.

Contributory (Secondary) .....(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) J. W. H. Hoedemaker M. D.

Jan 1 1916 (Address) Coeur d Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Jan 2 1916

20. UNDERTAKER: Hedal Undertaking Co C.D.A. — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No. 29

Primary Registration District No. 1050

(No. ....., ... St.)

File No. 13243

Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gerit Leonora Borgen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 7 (Day) 1914 (Year)

7. AGE: 1 Yrs. 8 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Coeur d'Alene Idaho

10. NAME OF FATHER B. J. Borgen

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Emma Howard

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. J. Borgen

(Address) Coeur d'Alene

15. Filed Jan 27. 1916. M. Howard, Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) – 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1915, to Jan 1916, that I last saw her alive on 1-24- 1916, and that death occured on the date stated above, at 2 a. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) Yrs. 2 mos. 6 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Alexander Eastman M. D.

1-25- 1916 (Address) 611 Garden Ave.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: J. C. Haddel — ADDRESS: C. d'A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13244

Registered No. 40

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29
Primary Registration District No. 1050

2. FULL NAME York B. Harren

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 12 (Day) 1915 (Year)

7. AGE: ..... yrs. 11 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Wilson Harren

11. BIRTHPLACE OF FATHER (State or Country): Wash

12. MAIDEN NAME OF MOTHER: Elsie Nagel

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wilson Harren
(Address) .....

15.
Filed Jan 31 1916 Mayo A Dorland
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 24 1916., to Jan. 27 1916., that I last saw h ine alive on Jan. 26. 1916, and that death occurred on the date stated above, at 4 9 M.

The CAUSE OF DEATH* was as follows:
Intestinal obstruction.

(Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno O Wood M. D.
Jan. 27 1916 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Jan 28 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 13245
Registered No. 47

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lamira Runyon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. (Month) ..... (Day) 1 (Year) 44

7. AGE: 72 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Edward White

11. BIRTHPLACE OF FATHER (State or Country): Eng

12. MAIDEN NAME OF MOTHER: Ann Lyon

13. BIRTHPLACE OF MOTHER (State or Country): Eng

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Neal Crumpton
(Address) Coeur d Alene

15. Filed 1-30 191.. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1915, to Jan. 29 1916, that I last saw h[illegible] alive on Jan 29 1916, and that death occured on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Wagner M. D.

Jan 30 1916 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Evans — DATE OF BURIAL: Jan 31 1916

20. UNDERTAKER: S J Quinn — ADDRESS: C d A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13347

Registered No. 37

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No. 29

Primary Registration District No. 1050

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arnold J Westerson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov. (Month) 20th (Day) 1904 (Year)

7. AGE: 11 Yrs. 2 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Minnisota

10. NAME OF FATHER J. A. Westerson

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Clara Holt

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. Westerson

(Address) Coeur d'Alene

15. Filed Jan 31 1916 Max A. Dolan Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1916, to Jan 21 1916, that I last saw h. m. alive on Jan 21 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Bright, disease

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute rheumatism

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Myers M. D.

1/21 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Jan 23 1916

UNDERTAKER: J. E. Herdrick — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13248

Registered No. 33

1. PLACE OF DEATH.

County of Coeur d'Alene

City of Kootenai

Registration District No. 29

Primary Registration District No. 1050

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Pickard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1834 (Year)

7. AGE: 82 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F A Blackwell

(Address) Coeur d'Alene

15. Filed 1-12 1916 M K Sorland Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) — 11 (Day) — 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 1915, to 1-11- 1916, that I last saw him alive on 1-11- 1916, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary): none natural causes

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Alexander Baerns M. D.

1-12- 1916 (Address) 611 Garden Ave C.d'A

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem

DATE OF BURIAL: Jan 13 1916

20. UNDERTAKER: S J Lewis

ADDRESS: C'dA

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Pleasant view (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29
Primary Registration District No. 1050

File No. 13249
Registered No. 34
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sadie Hines

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE: 27 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Operator
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Chas H Hines

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lelias Waggoner
(Address) Post Falls

15. Filed 1-18 1915 M A Soland Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan. (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

.....
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) No doctor ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Pleasant view cemetary — DATE OF BURIAL: Jan. 11 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 13250
Registered No. 32

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d Alene (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Draper
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1846 (Year)

7. AGE: 70 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: John Draper

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Susan Smith

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. A. Draper
(Address) Coeur d'Alene

15. Filed Jan. 7. 1916 McDonald, Local Registrar

SYRACUSE, N.Y. CO., PTRS. & BDRS. 24859

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191—, to ——— 191—, that I last saw h— alive on ——— 191—, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Heart Failure
Stoped dead in yard

(Duration) about Yrs. —— mos. —— ds.
Contributory (Secondary) Rheumatism for 2 years
(Duration — yrs. — mos. — ds.

(Signed) Alexander Carson M. D.
1/7/1916 (Address) 611 Garden Ave C d'A Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem — DATE OF BURIAL: Jan 9 1916

20. UNDERTAKER: D J Lee — ADDRESS: C d A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13251
Registered No. 33

1. PLACE OF DEATH.
Registration District No. 29
County of Kootenai
Primary Registration District No. 1050
City of Coeur d'Alene (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John W. Sherer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH: Dec. (Month) 13 (Day) 1 (Year)
7. AGE: 71 yrs. 1 mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer): Merchant
9. BIRTHPLACE (State or Country): Maryland
10. NAME OF FATHER: Sherer
11. BIRTHPLACE OF FATHER (State or Country): Dont-Know
12. MAIDEN NAME OF MOTHER: — Tracy
13. BIRTHPLACE OF MOTHER (State or Country): Dont-Know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Mc Queen
(Address) Palouse Hack
15. Filed 1-10 1916 W. H. Mc Vay Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) - 9 - (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 1-7- 1916, to 1-9- 1916, that I last saw h[illegible] alive on 1-9- 1916, and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Alexander Brown M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Jan 11 1916
20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D' Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 50
Primary Registration District No. 2121
(No. ....., ... St.)

File No. 13252
Registered No. 1

1. PLACE OF DEATH.
County of Lewis
City of Nezperce

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fennie Olive Stevens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: 1/4 Nez Perce Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 3 (Day) 1882 (Year)

7. AGE 33 ~~34~~ Yrs. 6 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Pierce Co. Washington

10. NAME OF FATHER Charles C. Newland

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Jennie L. Meek

13. BIRTHPLACE OF MOTHER (State or Country) Washington Co. Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. J. A. Kinyoski
(Address) Pete Idaho

15. Filed Jan 16 1916. R. E. Dunlop M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. January 14 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1916, to Jan 14 1916, that I last saw her alive on Jan 14 1916 and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Intaemia from acute nephritis

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Colorado of pneumonia
(Duration ..... yrs. ..... mos. 11 ds.

(Signed) E. L. Brooks M. D.
1/16 1916 (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fletcher Cemetery — DATE OF BURIAL: 1/17 1916

20. UNDERTAKER: J. L. Stevens — ADDRESS: Nezperce Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13253
Registered No. 2

1. PLACE OF DEATH.
County of Lemhi
City of Leo

Registration District No. 60
Primary Registration District No. 2129
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anne Louise Alexander

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	single

6. DATE OF BIRTH: Febr. (Month) 14 (Day) 1905 (Year)

7. AGE: 10 yrs. 11 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School-girl
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Leo, Idaho

10. NAME OF FATHER: G M. Alexander

11. BIRTHPLACE OF FATHER (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Harriet Isabelle Gillespie

13. BIRTHPLACE OF MOTHER (State or Country): N C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. M. Alexander
(Address) Leo Idaho

15. Filed 1/18 1916 R E Dunlap Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1916, to Jan 17 1916
that I last saw her alive on Jan 17 1916
and that death occurred on the date stated above, at 8:00 P.M.
The CAUSE OF DEATH* was as follows:
Peritonitis

..... (Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) appendicitis abscess
..... (Duration) ..... yrs. ..... mos. 5 ds.
(Signed) Elbert B. Rogers M. D.
1-17-1916 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
I.O.O.F Cemetery Leo	1-18 1916

20. UNDERTAKER	ADDRESS
Slover Undertaking Co.	Leo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2136
(No. ....., ... St.)

File No. 13255
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Lorenzo Burgoyne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Married

6. DATE OF BIRTH
August (Month) 22 (Day) 1861 (Year)

7. AGE
54 yrs. 4 mos. 27 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Merchant
(b) General nature of industry business, or dstablishment in which employed (or employer) ..... Mens Furnishings

9. BIRTHPLACE (State or Country) Wyoming

10. NAME OF FATHER Edward Burgoyne

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER Mary Eaynon ~~Burgoyne~~

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. L. Cruikshank
(Address) Montpelier Idaho

15.
Filed 1/22/ 191 6 W. H. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h— alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemmorrhage
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Appendicitis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo F Cudlip M. D.
1/21 1916 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Montpelier — DATE OF BURIAL: Jan 22nd 1916

20. UNDERTAKER: Vincent Bros — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13256

Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Dingle (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 7136

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mattie M. Sorenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: ~~June~~ Nov. 16 1853 (Month) (Day) (Year)

7. AGE: 63 yrs. 2 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers wife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bismark Denmark

10. NAME OF FATHER: Andrew Gunguson

11. BIRTHPLACE OF FATHER (State or Country): Bismark Denmark

12. MAIDEN NAME OF MOTHER: Christine Nelson.

13. BIRTHPLACE OF MOTHER (State or Country): Bismark Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Lyon M.D.
(Address) Montpelier Ida.

15. Filed Jan 18th 1916. N. A. Bingham Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. 16 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1915, to Jan. 16 1916, that I last saw her alive on Jan. 3 1916 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Pernicious Anemia.

(Duration) yrs. 7 mos. — ds.

Contributory (Secondary) —

(Duration) yrs. mos. ds.

(Signed) J. H. Lyon M. D.
1/16 1916 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dingle Idaho
DATE OF BURIAL: Jan 18th 1916

20. UNDERTAKER: John Sparks.
ADDRESS: Dingle

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13257

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bearlake

City of Montpelier

(No. ....., Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 87

Primary Registration District No. 2136

2. FULL NAME Mary Spidell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Exact date unknown (Month) (Day) 1845 (Year)

7. AGE: 71 Yrs. ..... Mos. ..... ds. near as known

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: — Davis

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Reuben R. Spidell

(Address) Rupert Idaho

15. Filed 1/11/16 — A. N. Kingsley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 1st (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1915, to Jan 1 1916, that I last saw her alive on Jan 1 1916, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senile Debility

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Jan 1 19 16 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Ida — DATE OF BURIAL: Jan 4 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13260

Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.

Registration District No. 4

Primary Registration District No. 1008

County of Canyon

City of Payette

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Allene Rose Pitts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. Aug (Month) 20 (Day) 1915 (Year)

7. AGE Yrs. 4 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Tom Pitts

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Cynthia Jane Inman

13. BIRTHPLACE OF MOTHER (State or Country) Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. P. Estlock

(Address) Payette Idaho.

15. Filed 1/15 1916

J. C. Woodward
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1915, to Jan 15 1916, that I last saw her alive on Jan 15 1916, and that death occured on the date stated above, at 2 10 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. Parker M. D.

1-15 1916. (Address) Payette

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Payette Idaho

DATE OF BURIAL Jan 16 1916

20. UNDERTAKER Glenn C Landon

ADDRESS Payette Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 4

Primary Registration District No. 1008

(No. .... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13261

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Payette

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cynthia Jane Pitts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 19 (Day) 1888 (Year)

7. AGE: 27 Yrs. 5 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Noah Inman

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Nancy Randolph

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Tom Pitts

(Address) Payette Idaho

15. Filed Jan 15 1916 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1915, to 1-12 1916, that I last saw h[illegible] alive on 1-12 1916, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Acute Phthisis

(Duration) one Yrs. [illegible] mos. [illegible] ds.

Contributory (Secondary) unknown

(Duration) unknown Yrs. mos. ds.

(Signed) C A Gerard M. D.

1-12 1916 (Address) Payette Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: Jan 14 1916

UNDERTAKER: Glenn E Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS-WORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 4

Primary Registration District No. 1008

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13262

Registered No. 9

1. PLACE OF DEATH.

County of Canyon

City of Payette

(No. 3 st. north Av. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Ann Solders

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: femal

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. April (Month) 7 (Day) 1843 (Year)

7. AGE: 72 Yrs. 8 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... house Keeping
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER: De Long

11. BIRTHPLACE OF FATHER (State or Country) Unknowen

12. MAIDEN NAME OF MOTHER: Parish

13. BIRTHPLACE OF MOTHER (State or Country) Unknowen

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. R. Soldiers
(Address) French Idaho

15. Filed Jan 18 1916 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 Dec. 20 1915, to Jan. 16 1916, that I last saw her alive on Jan. 16 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Unknown chronic Disease

(Duration) About 3 Yrs. mos. ds.

Contributory (Secondary) was an Epileptic

(Duration yrs. mos. ds.

(Signed) O. H. Avery M. D.

1/18/1916 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: Jan 17 1916

20. UNDERTAKER: Glenn C. Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13264
Registered No. 7

Registration District No. 4
Primary Registration District No. 1008
(No. .... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Payette
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine J. Doratty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May 23 1846 (Month) (Day) (Year)

7. AGE: 69 Yrs. 7 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: L. P. Palmetier

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mary Manning

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. J. Doratty
(Address) Payette Ida

15. Filed Jan 1 1916. J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
No physician in attendance
Broncho-pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) about 1 month
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. C. Woodward Registrar M. D.
1916 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida
DATE OF BURIAL: Jan 3 1916

20. UNDERTAKER: Glenn C. Landon
ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & STNRS. 24654.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
(No. ..... , ... St.)

File No. 13265
Registered No. 2

1. PLACE OF DEATH.
County of Canyon
City of Fruitland

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Kesler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~SINGLE~~, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. 7 (Month) 1 (Day) 1846 (Year)
7. AGE: 69 Yrs. 5 Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Virginia
10. NAME OF FATHER: Elias Kesler
11. BIRTHPLACE OF FATHER (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Mary Sink
13. BIRTHPLACE OF MOTHER (State or Country): Virginia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emma Kesler
(Address) Fruitland, Ida
15. Filed Jan 4 1916. J C Woodward Local Registrar

SYMS-YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 3 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1915 to Jan 3 1916, that I last saw him alive on Dec 30 1915, and that death occured on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia
(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W B Catron MD
Jan 4 1916. (Address) Payette Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: Jan 5 1916
20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13266
Registered No. 5

1. PLACE OF DEATH.
County of Canyon
City of Payette
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008

2. FULL NAME Helen Emma Comelsen
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: January (Month) 16 (Day) 1905 (Year)

7. AGE: 10 yrs. 11 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Schoo-girl
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Herman Comelsen

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna Haas

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herman Comelsen
(Address) Payette Idaho.

15. Filed Jan 6 1916 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15th 1915, to Jan 5th 1916 that I last saw her alive on Jan 5th 1916, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Exhaustion-Following Appendicitis

(Duration) ____ yrs. ____ mos. 20 ds.
Contributory (Secondary) Appendicitis
(Duration) ____ yrs. ____ mos. 8 ds.

(Signed) J. C. Woodward M. D.
Jan 6-1916 (Address) Payette Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho
DATE OF BURIAL: Jan 7 1916

20. UNDERTAKER: Glenn C Landon
ADDRESS: Payette Ida

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 13267
Registered No. 4

1. PLACE OF DEATH.
County of Canyon
City of Payette (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Timothy Driscoll

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 11 (Day) 1842 (Year)

7. AGE: 63 yrs. 11 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Book Keeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Peter Driscoll

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Liza Driscoll
(Address) Payette Ida

15.
Filed Jan 7 1916 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1915, to Jan 6 1916, that I last saw h was alive on Jan 6 1916, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) yrs. 1 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J R Woodward M. D.
Jan 7 1916. (Address) Payette Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: Jan 9 1916

20. UNDERTAKER: J. V. Adair — ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 13268
Registered No. 5

1. PLACE OF DEATH.
County of Canyon
City of Fruitland
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hannah Jane Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: July (Month) 4 (Day) 1837 (Year)

7. AGE: 38 yrs. 6 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Edward Roabic

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Valena Orr

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. M. Forsman
(Address) R.F.D. 1 Payette Ida

15. Filed Jan 10 1916 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1916, to Jan 9 1916
that I last saw her alive on Jan 9 1916
and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) I. R. Woodward M. D.
Jan 10, 1916 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence: Removal

19. PLACE OF BURIAL OR REMOVAL: Dillon Mont. | DATE OF BURIAL: Jan 10 1915

20. UNDERTAKER: D. Hudson Payette | ADDRESS: Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

DEC 7 1978

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy", "Collapse," "Coma," "Convulsions," "Debility, ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13269
Registered No. 6

Registration District No. 4
Primary Registration District No. 1008
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Payette
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Mc Glinchey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. June (Month) 26 (Day) 1838 (Year)
7. AGE: 77 Yrs. 6 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Orchardist
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Pennsylvania
10. NAME OF FATHER: William Mc Glinchey
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Bessie Dorian
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs John Mc Glinchey
(Address) Payette Idaho
15. Filed 1/15 1916 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 12 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from January 10 1916, to Jan. 11 1916, that I last saw him alive on Jan. 11 1916, and that death occured on the date stated above, at 10 30 AM.

The CAUSE OF DEATH* was as follows:
Unknown. Probably Embolism

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Sustained a fracture of left humerus on Jan. 10 1916
(Duration ..... yrs. ..... mos. 2 ds.

(Signed) O. H. Avery M. D.
1/15 1916 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: Jan 15 1916
20. UNDERTAKER: Glenn C. Landon — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & SONS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2086
(No. ....., ... St.)

File No. 13270
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Filer

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lorene Howard Small

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Baby

6. DATE OF BIRTH: ~~January~~ Sept 6 (Month) 22 (Day) 1915 ~~916~~ (Year)

7. AGE: Yrs. 4 Mos. 16 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Filer Twin Falls Co Idaho

10. NAME OF FATHER: Jesse F. Small

11. BIRTHPLACE OF FATHER (State or Country): Miami Co Kans

12. MAIDEN NAME OF MOTHER: Zella J. Kagen

13. BIRTHPLACE OF MOTHER (State or Country): Saline Co Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. F. Small
(Address) Filer Idaho

15. Filed 1-27 1916 a a Newberry Local Registrar

STAR - YORK CO., PTRS. & BKBS. 24655

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1916, to Jan 22 1916,
that I last saw him alive on Jan 22 1916
and that death occured on the date stated above, at 3 A M.
The CAUSE OF DEATH* was as follows:

Pneumonia.

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Abscess
(Duration ..... yrs. ..... mos. 2 ds.
(Signed) E A Woods M. D.
Jan 22 1916 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Ida — DATE OF BURIAL: 1-23 1916

20. UNDERTAKER: E E Drake — ADDRESS: Filer Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13271

Registered No. .....

1. PLACE OF DEATH.

County of Ada

City of Eagle

Registration District No. .....

Primary Registration District No. .....

(No. Eagle - Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Russell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 1 (Day) 1845 (Year)

7. AGE: 71 Yrs. 3 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Ben. Russell

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Ann Cross

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Russell

(Address) Eagle

15.

Filed 2-2 1916

R B Hoppis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 1914, to Feb 2 1916, that I last saw h— alive on Jan 20 1916 and that death occured on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrage

.....(Duration) 1 Yrs. 2 mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R B Hoppis M. D.

2/2 1916 (Address) Eagle

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery — DATE OF BURIAL: 2/3 1916

20. UNDERTAKER: Schreiber & Redmond — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4 13272

Registered No. 3

1. PLACE OF DEATH.

Registration District No. 92

County of Nez Perce

Primary Registration District No. WQUP 2170

City of Gifford (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marion Overman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
male	white	single

6. DATE OF BIRTH: Jan (Month) 11 (Day) 1914 (Year)

7. AGE: 2 yrs. 0 mos. 18 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Cha's Overman

11. BIRTHPLACE OF FATHER (State or Country): Oklahoma

12. MAIDEN NAME OF MOTHER: Lenora Alfrey

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred. N. Fels
(Address) Culdesac Ida

15. Filed 1-30 1916 E. E. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from XXXXXXXX 191X, to XXXXXXX 191X, that I last saw him alive on XXXXXXXXXXX 191..., and that death occurred on the date stated above, at 10 PM.

The CAUSE OF DEATH* was as follows:

Oedema Glotidis

(Duration) Short yrs. mos. ds.

Contributory (Secondary) Bronchitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Watts M. D.

1-20 1916 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Culdesac	1/31 1916

20. UNDERTAKER	ADDRESS
F.N.Fels	Culdesac

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13273

Registered No. 2

1. PLACE OF DEATH.
County of Nez Perce
City of Myrtle, Ida.

Registration District No. 92
Primary Registration District No. 2170
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph E. Gallacher.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June 17 1858
(Month) (Day) (Year)

7. AGE: 57 yrs. 6 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Joseph. Gallacher

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary A. Keese

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Gallacher.
(Address) Myrtle,

15.
Filed 1 — 3 1916
E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 3rd 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 191..., to ~ 191...
that I last saw h~ alive on ~ 191...
and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Apoplexy, (Cerebral)

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory General debility.
(Secondary)
..... (Duration) ~ yrs. ~ mos. ~ ds.

(Signed) J. J. Harrington M. D.
1916 (Address) Winfield, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Myrtle
DATE OF BURIAL: 1-4 1916

20. UNDERTAKER: Dennis McKay
ADDRESS: Myrtle Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4 13274

Registered No. 1

1. PLACE OF DEATH.

County of Nez Perce

City of Gifford (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 92

Primary Registration District No. 2170

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roy Olney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	single

6. DATE OF BIRTH

Oct (Month) 28 (Day) 1900 (Year)

7. AGE

15 yrs. 2 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work In School

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Benj E.Olney

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Dora Wetherby

13. BIRTHPLACE OF MOTHER (State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J.H.Olney

(Address) Gifford

15.

Filed 1/3 1916 E.E.Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan (Month) W 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Novv 15 1908, to Jan 1 1916, that I last saw him alive on Jan 1 1916, and that death occurred on the date stated above, at 12. M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 8 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E.E.Watts M. D.

1/3 1916 (Address) Gifford Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gifford Ida

DATE OF BURIAL: 1/4 1916

20. UNDERTAKER: W.E.Stoddard

ADDRESS: Gifford Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13278

Registered No. .....

Registration District No. 65

Primary Registration District No. 2145

1. PLACE OF DEATH.

County of Latah

City of Potlatch

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lois Trinly Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH. April (Month) 28th (Day) 1907 (Year)

7. AGE: 8 Yrs. 8 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minnesota.

10. NAME OF FATHER: Marshall Burr Smith

11. BIRTHPLACE OF FATHER (State or Country): Kansas.

12. MAIDEN NAME OF MOTHER: Clara Christerson

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marshall Burr Smith

(Address) Potlatch Idaho

15. Filed Jan. 5th 1916.

D. J. W. Thompson. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27th 1915, to Jan. 5th 1916, that I last saw him alive on Jan. 5th 1916, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Broncho pneumonia

(Duration ..... yrs. 6 mos. ..... ds.

(Signed) J. W. Thompson M. D.

1/5 1916 (Address) Potlatch Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery — DATE OF BURIAL: Jan 7 1916

20. UNDERTAKER: E. Anderson. — ADDRESS: Palouse. Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 13279
Registered No. 7

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME not named

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	

6. DATE OF BIRTH: Jan (Month) 5 (Day) 1916 (Year)

7. AGE: ... yrs. ... mos. ... ds. IF LESS than 1 day how many 10 hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chas H Goan

11. BIRTHPLACE OF FATHER (State or Country): Cala.

12. MAIDEN NAME OF MOTHER: Mable L Allen

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas H Goan
(Address) Grangeville Ida

15. Filed Feb 1 1916 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1916, to Jan 5 1916 that I last saw h~~im~~ alive on Jan 5 1916 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth
(Between 6 & 7 months)

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) G S Stockton M. D.
Feb 5 1916 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Barnes View	Jan 6 1916
20. UNDERTAKER: none	ADDRESS:

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 13280
Registered No. 4

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Coram

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March (Month) 29 (Day) 1844 (Year)

7. AGE: 71 yrs. 10 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming and Mining
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bristol England

10. NAME OF FATHER: William Coram

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jane Dunn

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Coram
(Address): Grangeville

15. Filed Feb 1 1916 G S Shutten Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. Sat (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1916, to Jan 15 1916, that I last saw him alive on Jan 15 1916, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Fell dead in hotel after eating his dinner

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Shutten M. D.

1/16 1916 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cain Creek — DATE OF BURIAL: Jan 19 1916

20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 2161

File No. 13281

County of Idaho

City of Grangeville (No. ....., ... St.)

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Radolph C. Whitman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: September 23 1866 (Month) (Day) (Year)

7. AGE: 49 yrs. 3 mos. 23 ds.

IF LESS than 1 day how many ..1.5.. hrs. or ..4.5.. mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York State

10. NAME OF FATHER: George Whitman

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Sarah B English

13. BIRTHPLACE OF MOTHER (State or Country): Cayuga Lake N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank V. Whitman
(Address) Walkerville Montana

15. Filed Jan 22 1916 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1916 to Jan 17 1916 that I last saw h~~e~~ alive on Jan 17 1916 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.

1/18 1916 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted ~~if not at place of death~~?

Former or usual residence

19. ~~PLACE OF BURIAL OR~~ REMOVAL: Cayuga Lake N. York | DATE OF BURIAL ..... 191..

20. UNDERTAKER: W E Graham | ADDRESS Grangeville

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2001
File No. 13282
Registered No. 2

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Wesley Stilwell
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: ~~Black~~ White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: April 12 1837 (Month) (Day) (Year)

7. AGE: 78 yrs. 9 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Edgar Co Ill.

10. NAME OF FATHER: Jacob Stilwell

11. BIRTHPLACE OF FATHER (State or Country): dont know

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W F Stilwell
(Address) Grangeville Idah

15. Filed Jan 1 1916 G S Stocklin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 5 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1915, to Jan 5 1916 that I last saw h~~im~~er alive on Jan 4 1916 and that death occurred on the date stated above, at P M.

The CAUSE OF DEATH* was as follows:
La Grippe
Angina Pectoris
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) La Grippe
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stocklin M. D.
1/6 1916 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Jan 7 1916

20. UNDERTAKER: G S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13283
Registered No.

1. PLACE OF DEATH.
County of Nez Perce
City of Lapwai
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2174
Primary Registration District No. 97
(No. ....., ... St.)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed baby Miles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M	W	

6. DATE OF BIRTH
1 (Month) 21 (Day) 1916 (Year)

7. AGE
..... yrs. ..... mos. 2 ds.
IF LESS than 1 day how many ..... *hrs.* or ..... *mins.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Alvo C Miles

11. BIRTHPLACE OF FATHER (State or Country) Ore

12. MAIDEN NAME OF MOTHER Rhena Fowler

13. BIRTHPLACE OF MOTHER (State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John N. Alley
(Address) Lapwai

15.
Filed 1-24 191 John N Alley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
1 (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1916, to Jan 23 1916, that I last saw h— alive on Jan 22 1916, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Malformation of the Bowels

(Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) Malnutrition
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John N. Alley M. D.
1-23-1916 (Address) Lapwai

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lawyers	Jan 24 191
20. UNDERTAKER Dorf Kuhn	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13284
Registered No.

1. PLACE OF DEATH
County of Nez Perce
City of Culdesac
Registration District No. 2154
Primary Registration District No. 97
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Emerick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1846 (Year)

7. AGE: 70 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Down Penn

10. NAME OF FATHER: Lasley Hargrett

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John N. Alley
(Address) Kendrick

15. Filed Jan 31 1915 John N Alley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 31 (Day) 1915 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1915 to Jan 31 1915, that I last saw her alive on Jan 24 1915 and that death occurred on the date stated above, at 8 M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... yrs. ..... mos. 21 ds.

Contributory (Secondary): none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John N. Alley M. D.
1-31 1915 (Address) Kendrick

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Culdesac — DATE OF BURIAL: 2-1 1915

20. UNDERTAKER: Brown Bros — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13285
Registered No. .....

1. PLACE OF DEATH
County of Ben Pierce
City of Lapwai
Registration District No 2694
Primary Registration District No 94
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Hoyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. 1 (Month) 18 (Day) 916 (Year)

7. AGE ..... Yrs. ..... Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wm. Hoyer

11. BIRTHPLACE OF FATHER (State or Country) Ore

12. MAIDEN NAME OF MOTHER Jane Forcupine

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John B Kelley
(Address) Lapwai

15. Filed 2-2-16 John B Kelley Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-31 1916, to 2-1 1916, that I last saw h- alive on Jan 31 1916 and that death occured on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Mother Tuberculosis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John B Kelley M. D.
2-2 1916 (Address) Lapwai Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sweet Water — DATE OF BURIAL 2-2 1916

20. UNDERTAKER None — ADDRESS —

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13286

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Lapwai

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2134

Primary Registration District No. 97

(No. ....., ... St.)

2. FULL NAME Joseph W. Lane

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 6 (Day) 1880 (Year)

7. AGE: 35 yrs. 11 mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Salesman
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: John Lane

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Hattie Sherard

13. BIRTHPLACE OF MOTHER (State or Country): Calif

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Roy C. Lane
(Address): Lapwai, Idaho

15. Filed Jan 31 1916 John H. Allen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1916 to Jan 30 1916
that I last saw h.. alive on Jan 20 1916
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac regurgitation

(Duration) 3 yrs. mos. ds.

Contributory (Secondary) Pulmonary

(Duration) 28 yrs. mos. ds.

(Signed) John H. Allen M. D.

1-30 1916 (Address) Lapwai Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho | DATE OF BURIAL: 1-31 1916

20. UNDERTAKER: Wm Ross | ADDRESS: Lapwai Idaho

SYMS - YORK CO., PTRS. & BDRS. 10-'60

V. S.—No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. Age should be stated exactly. Physicians should state cause of death in plain terms, that it may be properly classified. The "Special Information" for persons dying away from home should be given in every instance.

PLACE OF DEATH

County of Benewah,

Town of Coeur d'Alene

or

City of Reservation (No. ..... St.; ..... Ward.)

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information."]

WASHINGTON STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 13287

File No. 1

Registered No. .....

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

Full Name Alice Leo

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR: Indian

DATE OF BIRTH: May (Month) 18 (Day) 1914 (Year)

AGE: 1 year, 7 months, 23 days

SINGLE, MARRIED, WIDOWED, OR DIVORCED: Infant

BIRTHPLACE (State or country): Coeur d'Alene Reservation

NAME OF FATHER: Victor Leo

BIRTHPLACE OF FATHER (State or country): Coeur d'Alene Reservation

MAIDEN NAME OF MOTHER: Teresa Mary Joseph

BIRTHPLACE OF MOTHER (State or country): Coeur d'Alene Reservation

OCCUPATION: Housewife

THE ABOVE STATED PERSONAL PARTICULARS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

(Informant) Victor Leo

(Address) De Smet, Idaho

Filed Jan. 13, 1916 John Fast, Asst. Registrar.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan (Month) 10 (Day) 1916 (Year)

I HEREBY CERTIFY, That I attended deceased from Dec 11 1915, to Jan 10 1916

that I last saw h alive on Dec 13 1915

and that death occurred, on the date above, at 12 m.,

The CAUSE OF DEATH was as follows: Pneumonia, following attack of Gastro enteritis

..... (Duration) ..... Days

Contributory .....

..... (Duration) ..... Days

(Signed) J. A. Nelson, M. D.

Jan 10 1916 (Address) Tekoa Wn.

SPECIAL INFORMATION only for Hospitals, Institutions, Transients or Recent Residents.

Former or Usual Residence .....

How Long at Place of Death? .....

Where was Disease Contracted? .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
DeSmet Idaho	Jan 11 1916

UNDERTAKER	ADDRESS
John Fast	DeSmet, Idaho

FORM V. S. No. 5-25 M. 1-10-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Ada — Registration District No. 2
City of Boise, Ida — No. 602 Sherman St. — Primary Registration District No. 1004
File No. 13288
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Oscar Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. March (Month) 15 (Day) 1850 (Year)

7. AGE: 65 Yrs. 9 Mos. 16 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Police officer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lynchburg Virginia

10. NAME OF FATHER: Geo. Dabney Phillips

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Mary Garland Childs

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hattie A. Phillips
(Address) 601 Sherman Boise

15. Filed 1/3 1916 — E. E. Caton, Local Registrar

SYMS - YORK CO., PTRS. & BOXE. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 1 (Day) 1916

17. I HEREBY CERTIFY, That I attended deceased from 1/1/1916, to 1/1 1916, that I last saw h— alive on 1/1 1916 and that death occured on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterio Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Dewey M. D.

1/3 1916 (Address) Taft Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/4 1916

20. UNDERTAKER: Schreiber & Siedenfaden — ADDRESS: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13289

Registered No. 2

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 113 Washington St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 31st (Day) 1915 (Year)

7. AGE: — Yrs. — Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: Leonard Hall

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: ~~Thomas~~ Elvanie Howell

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leonard Hall

(Address)

15. Filed 1/3 1916 E. F. Caton Local Registrar

Shurtz

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 3rd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1915, to Jan 3 1916, that I last saw him alive on Jan 3 1916 and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Gastric Haemorrage

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) La Grippe

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R E Shurtz M. D.

19 .... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 3 days. In the State ..... yrs. ..... mos. 8 days

Where was disease contracted if not at place of death? Hosp

Former or usual residence Same

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/4 1915

20. UNDERTAKER: Schreiber & Siebenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13291

Registered No. 4

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 1612 N. 11th St.)

Registration District No. ____

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Effie J. Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. June (Month) 17 (Day) 1870 (Year)

7. AGE 45 Yrs. 6 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Asa W. Hoagland

11. BIRTHPLACE OF FATHER (State or Country) Ann.

12. MAIDEN NAME OF MOTHER Aurilla Holcomb

13. BIRTHPLACE OF MOTHER (State or Country) Ann.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. D. Miller
(Address) Boise

15.
Filed 1/5 1916 E. F. Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1915, to Jan 5 1916, that I last saw her alive on Dec 25 1916, and that death occured on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(Duration) 6 Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____ (Duration ____ yrs. ____ mos. ____ ds.

(Signed) Maurice H. Talmon M. D.
1/6 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/6 1916

20. UNDERTAKER: Schreiber & Sidwell Undertaking — ADDRESS: Boise

Maurice Talmon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13292

Registered No. 5 1

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 1822 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margereth Ash

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov 29 1915 (Month) (Day) (Year)

7. AGE: 0 Yrs. 1 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ada Co. Idaho.

10. NAME OF FATHER Homer E. Ash

11. BIRTHPLACE OF FATHER (State or Country) Ills.

12. MAIDEN NAME OF MOTHER Stella Thornton

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Homer E Ash

(Address) .....

15. Filed I/5 191 6

E. F. Caton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 5th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1916, to Jan 5 1916, that I last saw her alive on Jan 5 1916, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Uremic Convulsions

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) J.S. Springer M. D.

Jan 5 1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Ada Co. Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/6 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise.

BYNS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13293
Registered No. 6

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. St., Sisters Hosp St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Barnhart Matteson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 14 (Day) 1858 (Year)

7. AGE: 57 yrs. mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: John Matteson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Otto Matteson
(Address) 418 No 18th St.

15.
Filed 1/6 1916 E. F. Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1915, to Jan 3 1916 that I last saw h[illegible] alive on Jan 3 1916 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) yrs. mos. ds.
Contributory (Secondary) Edema of Lungs
(Duration) yrs. mos. ds.

(Signed) J.S. Springer M. D.
Jan 5 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/7 1916
20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13294

Registered No. 71

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Carroll

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. May (Month) 7 (Day) 1837 (Year)

7. AGE: 78 Yrs. 7 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. H. Stout

(Address) Boise Ida

15.

Filed Jan 6 1916 W. F. Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1916, to Jan 2 1916 that I last saw him alive on Jan 2 1916 and that death occured on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Tobacco

Pneumonia

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) [illegible] M. D.

1/5 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 1/7 1916

20. UNDERTAKER: Schreiber & Hidenfadin — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 13295
Registered No. 8

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William O Connell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) (Year): 1869

7. AGE: 46 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York U.S.

10. NAME OF FATHER: not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Sister M Fenton
(Address) Boise

15. Filed 1/8 1916 E. F. Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1915, to Jan 2 1916, that I last saw h. alive on Jan 2 1916, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Laryngeal Tuberculosis
Pulmonary T. B
(Duration) Yrs. 3 mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) R E Blurly M. D.
1/3 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 3 mos. — days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence St Alphonsus Boise Ada County

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 1/10 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

SYMS – YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13296

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

2. FULL NAME Samuel L. Greig

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 22 (Day) 1872 (Year)

7. AGE: 43 Yrs. 6 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Contractor

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Hugh Greig

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Margaret Greig
(Address) Boise Idaho

15. Filed I/8 191 6 E. F. Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
..... (Month) ..... (Day) ..... 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 191 5 to Jan 6 191 5
that I last saw h alive on Jan 6 191 5
and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia
Following Grippe
Cardiac Heart Failure

..... (Duration) ..... Yrs. 5 mos. ..... ds.

Contributory (Secondary) .....
Duration ..... yrs. ..... mos. ..... ds.

1/6 191 6 (Signed) [illegible] M. D.
(Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos. 2 days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 1/9 1916

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13297
Registered No. II

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 906 McKinley St.)

2. FULL NAME Jennie Parkes

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Married

6. DATE OF BIRTH: Dec 9 (Month) 1869 (Year)

7. AGE: 46 yrs. — mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Joseph Winemiller

11. BIRTHPLACE OF FATHER (State or Country): Not obtainable

12. MAIDEN NAME OF MOTHER: Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. F. Parkes
(Address) Boise

15. Filed 1/8 1916 E. F. Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 6th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1910 191.., to Jan 6th 1916, that I last saw her alive on Jan 5th 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Dropsy and Asthma

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Heart Lesions
(Duration) 2 yrs. ..... mos. ..... ds.

1-7-16 (Signed) H. H. Baer M. D.
19.. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Masonic Cemetery	Jan 9 1916
20. UNDERTAKER	ADDRESS
Ivy D Summers	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13298

Registered No. 13

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 1215 Warm Springs Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ben Sherman Eastman Jr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 2nd 1914 (Month) (Day) (Year)

7. AGE: 1 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: Ben S. Eastman

11. BIRTHPLACE OF FATHER (State or Country): Boise, Idaho

12. MAIDEN NAME OF MOTHER: Edith L. Kading

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John M. Reggan

(Address) Boise, Idaho

15. I/II 6 E. F. Caton

Filed ..... 191 .....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany 11 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9th 1915, to Jany 11 1916, that I last saw him alive on Jany 11 1916, and that death occured on the date stated above, at 12 15 M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Whooping Cough

(Duration) ..... Yrs. ..... mos. 40 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James T. Alexander M. D.

1/11 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 1/12 1916

20. UNDERTAKER: Schreiber & Siebenpfeiffer — ADDRESS: Boise

BYRD - YORK CO., PTRS. & BKBS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13299
Registered No. 14

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hosp. St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alexander P. Crawford.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (write the word): Widower

6. DATE OF BIRTH: Feb (Month) 2 (Day) 1831 (Year)

7. AGE: 84 yrs. 11 mos. 6 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Not Obtainable.

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alexander W. Crawford.
(Address)

15. Filed I/II 191 6 E. F. Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916 to Jan 8 1916, that I last saw h[illegible] alive on Jan 8 1916, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Bosch M. D.

Jan 11 1916 (Address) Mc Carty Bldg Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Cemetery — DATE OF BURIAL: Jan 13 1916

20. UNDERTAKER: Frey & Gemmer — ADDRESS: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada.
City of Boise.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 2006 No 18. St.)

File No. 13301
Registered No. 16
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thelma Kearnes. KEARNS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Single

6. DATE OF BIRTH: Feb 4 (Month) (Day) 1914 (Year)

7. AGE: 1 yrs. 11 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Ida.

10. NAME OF FATHER: H. C Kearnes KEARNS

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Lillian Justa

13. BIRTHPLACE OF MOTHER (State or Country): Not Ascertained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): H C Kearnes
(Address): Boise City Idaho

15. Filed I/12 1916 E. . Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-8 1916, to 1-11 1916, that I last saw her alive on 1-11 1916, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Status lymphaticus
following Tonsil
Operation
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. H. Falconer M. D.
1-12 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence:

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Jan 12 1916

20. UNDERTAKER: Fry & Summers | ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH—BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho } ss.
County of Ada

Certificate No. 13301

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of (Birth or Death)
for (Name on Original Certificate) who (Was Born or Died) on (Date of Event)
in (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Name	Kearnes	Kearns

Subscribed and sworn to before me this 21st day of November 1950.

Notary Public, residing at Boise Idaho
My commission expires Sept. 25, 1953
(Seal)

Signed Mrs Lillian Kearns
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of } ss.
County of

[This Affidavit **MUST** Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this day of , 19

Notary Public, residing at
My commission expires
(Seal)

Signed
(Signature of Any Credible Person)

(Street Address, City, State)

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada.
City of So Boise
If death occcse away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 2 1004
(No. ....., ... St.)

File No. 13302
Registered No. 17
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME M Mabel Barnum.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
F.	White	Married

6. DATE OF BIRTH
Sep. (Month) 9 (Day) 1882 (Year)

7. AGE
33 yrs. 4 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife.
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Nebraska.

10. NAME OF FATHER Theodore Howe.

11. BIRTHPLACE OF FATHER (State or Country) New York.

12. MAIDEN NAME OF MOTHER Gertrude Larrabee.

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W Willard Barnum
(Address) Boise

15.
Filed 1/14 1916 E. F. Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2nd 1915, to Jan 14th 1916, that I last saw h[illegible] alive on Jan 13th 1916, and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Lungs - Metastasis from Breast.

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory Carcinoma of Breast
(Secondary) first noticed Nov. 1914
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L M. Taylor M. D.
1/14 1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Jan 17 1916

20. UNDERTAKER: Fry & Summers. ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13303

Registered No. 18

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1024

(No. 1415 W. Franklin St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Willard B. Brink

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 13 (Day) 1855 (Year)

7. AGE: 60 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Newton Brink

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Lucy Lyons.

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. F. Roberts

(Address) Nampa, Idaho.

15.

Filed 1/17 1916 E. E. Eaton Local Registrar

EVANS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1916, to Jan 15 1916, that I last saw h alive on Jan 15 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Maurice D. Talbman M. D.

1/16 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Nampa, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cemetery Nampa, Id. DATE OF BURIAL: 1/17 1916

20. UNDERTAKER: Schreiber & Sidenfaden ADDRESS: Boise, Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 13304
Registered No. 20

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 1903 Eastman St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew W. Brandt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. 2 (Month) 2 (Day) 1830 (Year)

7. AGE 86 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER a a

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. Swart
(Address) Sweet Ida

15. I/18 6 E. F. Caton
Filed ..... 191 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 17 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26th 1915, to Jan. 17th 1916, that I last saw h[illegible] alive on Jan 17th 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Senility
.....
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Louis Bauch M. D.
1-18 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Boise past 10 Years

19. PLACE OF BURIAL OR REMOVAL Sweet Cemetery Sweet Ida | DATE OF BURIAL 1/20 1916

20. UNDERTAKER Schreiber & Sidenfaden | ADDRESS Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

Cochrane

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13305

Registered No. 21

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 1004

(No. 1016, N 15 St. St.)

2. FULL NAME Arthur Hugh Cochrane

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug 4 (Month) (Day) 1873 (Year)

7. AGE: 42 yrs. 5 mos. 14 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cigar Merchant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Alonzo Cochrane

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Mary Jett

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs A Cochrane

(Address) 1016 N 15th St

15. I/19 6 E. F. Caton

Filed ..... 191... Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 18 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1916, to Jan 18 1916, that I last saw him alive on Jan 18 1916 and that death occurred on the date stated above, at 12 30 M.

The CAUSE OF DEATH* was as follows:

Nephritis

.....(Duration).....yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) O. H. Parker M. D.

19.... (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill | DATE OF BURIAL: Jan 21 1916

20. UNDERTAKER: Fry & Summers | ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13306
Registered No. 22
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 411 Resigue St.)

2. FULL NAME Charles L. Roberts.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	

6. DATE OF BIRTH: March 16 1915.
(Month) (Day) (Year)

7. AGE: yrs. 10 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: William A. Roberts

11. BIRTHPLACE OF FATHER (State or Country): Kentucky.

12. MAIDEN NAME OF MOTHER: Emma Peterson.

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Roberts
(Address) 411 Resigue St

15. Filed I/19 1916 E. F. Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. 17th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1916; to Jan 17 1916; that I last saw him alive on Jan 17 1916, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Acute Bronchitis

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Colitis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Benner M. D.
Jan 18 1916 (Address) Thorne Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Jan 19 1916

20. UNDERTAKER: Ivy & Simmons ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13307

Registered No. 23

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 2 1004

Primary Registration District No.

County of Ada.

City of Boise. (No. 1014 Ns 10. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James C. Porter.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): M

6. DATE OF BIRTH: June 26 (Month) (Day) 1881 (Year)

7. AGE: 34 yrs. mos. ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Street car conductor
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania.

10. NAME OF FATHER: John Porter.

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable.

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. J. Evans
(Address) 2824 Idaho St

15.
Filed 1/20 1916 E. E. Caton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1st 1916 to Jan 18 1916, that I last saw h alive on Jan 17 1916, and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:
Mitral insufficiency

(Duration) yrs. mos. ds.

Contributory (Secondary): Rheumatism

(Duration) yrs. mos. ds.

(Signed) J. S. Springer M. D.

Jan 19 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Jan 20 1916

20. UNDERTAKER: Frye Summers. — ADDRESS: Boise.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

20

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13308

Registered No. 24

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 112 E Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lloyd B. Wineland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) (Year): 1882

7. AGE: 33 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H B Brown

(Address) Steinman Idaho.

15. Filed I/20 1916

E. F. Cotton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 18 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1915, to Jan 18 1916, that I last saw h.im alive on Jan 18 1916, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... Yrs. 10 mos. ..... ds.

(Signed) H B Smith M. D.

1/19 1916 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos. 5 days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence: Boise County Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/20 1916

20. UNDERTAKER: Schreiber & Siefenfaden — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24653

Dr. Smith

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH 2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada.
City of Boise,
(No. 1519 No 15 St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1004

File No. 13309
Registered No. 25
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harrold Holsted

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 30 (Day) 1907 (Year)

7. AGE: 8 yrs. 4 mos. 28 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mouse.
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Earl L. Holsted.

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Clara Simms.

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. R. J. Butts.
(Address)

15.
Filed I/20 1916 E. F. Caton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1916, to Jan 18 1916, that I last saw h— alive on Jan 18 1916 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia
La Grippe
(Duration) yrs. mos. 6 ds.
Contributory (Secondary) La Grippe
(Duration) yrs. mos. 10 ds.
(Signed) R C Blunt M. D.
1/20 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill
DATE OF BURIAL: I/20 1916

20. UNDERTAKER: Fuyo Summers
ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13310

Registered No. ____

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 324 Michigan St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Henry Foster

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Aug (Day) 14 (Year) 1906

7. AGE: 9 Yrs. 5 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: J. H. Foster

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: R. D. Foster

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Foster

(Address) Boise Ida

15. Filed 1/21 191 6 E. F. Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Jan (Day) 20 (Year) 1916

17. I HEREBY CERTIFY, That I attended deceased from Jan 18th 1916, to Jan 20th 1916, that I last saw him alive on Jan 20th 1916, and that death occured on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) John Bower M. D.

1-21 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery DATE OF BURIAL: 1/22 1916

20. UNDERTAKER: Schreiber & Sidenfaden ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 13311
Registered No. 272

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 617 1/2 S. 13th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME M. M. Burd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Feb (Month) 1 (Day) 1832 (Year)

7. AGE 85 Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: Jacob Burd

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Geo Dorrman
(Address) Boise

15. Filed 1/21 1916 [illegible] Cat or Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1916, to Jan 20 1916, that I last saw h living on Jan 18 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Chronic interstitial nephritis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Apoplexy

(Duration ..... yrs. ..... mos. 10 ds.

(Signed) M. H. Zallenmyer M. D.

1-21 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery
DATE OF BURIAL: 1/24 1916

20. UNDERTAKER: Schreiber & Lindenfeld
ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada — Registration District No. 2

City of Baise — Primary Registration District No. I004

(No. 703 N. 8. St.) — File No. 13312

Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give NAME instead of street and number.

2. FULL NAME Lucinda Gumbert Pfaff Peffley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Oct (Month) 22nd (Day) 1876 (Year)

7. AGE: 39 Yrs. 3 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Baise, Idaho

10. NAME OF FATHER: Geo Gumbert

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mary C. Turner.

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary C. Gumbert

(Address)

15. Filed I/25 1916

E. F. Caton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1913, to Jan 24 1916, that I last saw h... alive on ... 191..., and that death occured on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) Geo Calvert M. D.

19.... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 1/25 1916

20. UNDERTAKER: Schreiber & Eidemon — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 1004
File No. 13313
Registered No. 50

1. PLACE OF DEATH.
County of Ada.
City of Boise.
(No. 1907 No 17 St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Allen V Webster.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male.	White	Married (or widowed.)

6. DATE OF BIRTH
March 11 1844
(Month) (Day) (Year)

7. AGE
71 yrs. 10 mos. 14 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) —

9. BIRTHPLACE
(State or Country) Louisiana.

10. NAME OF FATHER Samuel Webster.

11. BIRTHPLACE OF FATHER
(State or Country) Louisiana.

12. MAIDEN NAME OF MOTHER Frances Fields.

13. BIRTHPLACE OF MOTHER
(State or Country) Louisiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. B. Miller
(Address) 921 Fort St

15.
Filed 1/26 1916 E. F. Caton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
1 25 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1915, to Jan 25 1916
that I last saw h~~im~~ alive on Jan 24 1916
and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Senility

.....(Duration).....yrs.....mos.....ds.

Contributory
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) Fred W Schuyler M. D.
1/26 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	Jan 26 1916

20. UNDERTAKER	ADDRESS
Fry & Summers Co.	Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13314

Registered No. 51

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 1718 Harrison Blvd St.)

2. FULL NAME William Foster Boad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June 10 1896 (Month) (Day) (Year)

7. AGE: 19 yrs. 7 mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: John Boad

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ester Tradewell

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Clarence Lunstrum

(Address) 1718 Harrison Blvd.

15.

Filed 1/27 191 6 E. F. Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1915, to Jan 24 1916 that I last saw h[illegible] alive on Jan 1916 and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Dilatation of Heart

(Duration) yrs. mos. ds.

Contributory (Secondary) Arteriosclerosis & Pneumonia

(Duration) yrs. mos. ds.

(Signed) Fred A Tetmeyer M. D.

1/27 1916 (Address) Falk Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery DATE OF BURIAL: Jan 29 1916

20. UNDERTAKER: Fry & Summers ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada.

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 914, N. 8th St. St.)

File No. 13316

Registered No. 34

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harold O. Roberts.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH

Jan (Month) 30 (Day) 1900 (Year)

7. AGE

15 yrs. 11 mos. 29 ds.

IF LESS than 1 day how many .....hrs. or .....mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Student

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Colorado.

10. NAME OF FATHER J. Cyrus Roberts.

11. BIRTHPLACE OF FATHER (State or Country) Kentucky.

12. MAIDEN NAME OF MOTHER Alice Swope.

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Cyrus Roberts

(Address) .....

15.

Filed I/29 191 6 E. F. Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1915, to Jan 29 1916, that I last saw h-m alive on Jan 29 1916 and that death occurred on the date stated above, at 10 20 M.

The CAUSE OF DEATH* was as follows: -

Polyvalvular insufficiency and mitral stenosis

(Duration) 3 yrs. mos. ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Maurice Holleman M. D.

1/29 1916 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Jan 30 1916

20. UNDERTAKER	ADDRESS
Fry & Summers	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13317

Registered No. 35

1. PLACE OF DEATH

County of Ada

City of Boise

Registration District No.

Primary Registration District No. 1004

(No. St. Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Georgie Genevieve Garvin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	White	Single

6. DATE OF BIRTH: Sep (Month) 10 (Day) 1902 (Year)

7. AGE: 13 yrs. 4 mos. 19 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Geo G. Garvin.

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Media Ellis.

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo A Garvin

(Address)

15. Filed I/31 191 6 E. E. Paton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 28 191 , to Jany 29 1916, that I last saw h alive on Jany 29 1916 and that death occurred on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows:

Shock - following
RR accident

(Duration) yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) James L Stewart M. D.

1/31 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell Ida. DATE OF BURIAL: 191

20. UNDERTAKER: Fry & Summers ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13318
Registered No. 2

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ada,
City of Meland Valley (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8
Primary Registration District No. 2004

2. FULL NAME John H. Moore

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct 4 (Month) (Day) 1858 (Year)

7. AGE: 57 yrs. 3 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Doctor
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Abigail Moore

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Henderson

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eva D Moore
(Address) Boise R.D 1.

15.
Filed Jan 11th, 1916 E.F. Caton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. 10 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased from Jan 10 1916 to ..... 191..., that I last saw h— alive on ~~dead~~ Jan 10 1916, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Valvular insufficiency
Natural Causes
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner ~~M. D.~~ Ada County
1/11 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Big Timber Mont. DATE OF BURIAL: Jan 14 1916

20. UNDERTAKER: Fry & Summers ADDRESS: Boise Idaho

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13319

Registered No. 1

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

County of Ada

City of Wylie Station (No. Wylie Station St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha B. Durell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Apr 21 (Month) (Day) 1838 (Year)

7. AGE: 77 yrs. 8 mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: William Dilworth

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mary Bailey

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margery D. Wilcox

(Address) R. 1, Boise, Idaho

15.

Filed January 7th, 1916 E. E. Caton. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January 6 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1915, to Jan 6th 1916, that I last saw h.r alive on Jan 4th 1916, and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Senility - No definite disease discovered

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Taylor M. D.

Jan. 7th 1916 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill | DATE OF BURIAL: Jan. 7 1916

20. UNDERTAKER: Frey & Summers | ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13320
Registered No. 3

1. PLACE OF DEATH.
County of Ada
City of Ustick
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8
Primary Registration District No. 2004
(No. ..... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nora Elene Hardy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan 4 1916 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ustick Ida.

10. NAME OF FATHER: J J Hardy

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Nord. Hardy

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J Hardy
(Address) Ustick

15.
Filed Jan 12th, 1916 E.F. Caton. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 12 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191.., to 191..., that I last saw h.. alive on Jan 8 1916 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Premature Birth,

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W O Tuthey M. D.
1-12 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Jan 13 1916

20. UNDERTAKER: Fry & Summers | ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13321

Registered No. 4

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

County of Ada

City of Soldiers Home, (No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William O'Dougherty

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: ____ (Month) 1842 (Year)

7. AGE: 74 yrs. ____ mos. ____ ds.

IF LESS than 1 day how many ____ hrs. or ____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. Edsin McCobb D.C.
(Address) 418 Idaho Bldg

15.

Filed Jan 15th. 1916 E.F. Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1915, to Jan 1916 that I last saw h in alive on Jan 13 1916, and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Pulmonary Abscess

(Duration) 0 yrs. ____ mos. 2 ds.

Contributory (Secondary) Pneumonia Lobar

(Duration) ____ yrs. 2 mos. ____ ds.

(Signed) Fred. C. Fullmer M. D.

1/15 1916 (Address) Salt Lake

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho. DATE OF BURIAL: Jan 16 1916

20. UNDERTAKER: Fry & Summers ADDRESS: Boise Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13322

Registered No. 5

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

County of Ada

City of Soldiers Home (No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert B. Baldwin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ____ (Month) 1 (Day) 1834 (Year)

7. AGE: 82 yrs. ____ mos. ____ ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. G. Burnett
(Address) Soldiers' Home

15.

Filed January 19th 1916 T. F. Catron Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1915, to 1/17 1916 that I last saw h[illegible] alive on 1/15 1916 and that death occurred on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Fred A. Tietzsworth M. D.

1/18 1916 (Address) Soldiers Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho | DATE OF BURIAL: Jan 19 1916

20. UNDERTAKER: Fry & Summers | ADDRESS: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8
Primary Registration District No. 2004
(No. Soldiers Home St.)

File No. 13323
Registered No. 6
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles H. Luther

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Not Obtainable (Month) 1 (Day) 1834 (Year)

7. AGE: 82 yrs. ___ mos. ___ ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. G. Burnell
(Address) Soldiers' Home

15. Filed 2/I 191 6 E. F. Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916 to Jan 30 1916, that I last saw him alive on Jan 28 1916 and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) Unable to get alcohol

(Duration) ... yrs. ... mos. ... ds.

(Signed) Fred G. Tietzen M. D.

2/ 1916 (Address) Jack Bld

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Feb 2 1916

20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms; so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada.
City of Near Barberton. (No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8
Primary Registration District No. 2004

File No. 13324
Registered No. 7
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hiram A Cressay.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	White	Single

6. DATE OF BIRTH: March (Month) 14 (Day) 1910 (Year)

7. AGE: 5 yrs. 10 mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Mortimer C. Cressy.

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Anna G. Turner

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mortimer Charles Cressy
(Address) 1116 Miller St Boise Ida

15. Filed Feb 1st, 1916 E.F. Caton, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 30 1916 to ____ 191__, that I last saw h[illegible] alive on Jan 30 1916 and that death occurred on the date stated above, at ____ M.
The CAUSE OF DEATH* was as follows: Unknown

Frozen to death

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) Found frozen to death 10 miles from Boise

(Duration) 1 hr mos

(Signed) Clyde E. Summers M. D.
2/1 1916 (Address) Boise Ida Coroner Ada Co

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Feb 2 1916

20. UNDERTAKER: Jay & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 12325
Registered No. 27
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes Isabella Morton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fem	White	Single

6. DATE OF BIRTH: Jan 28 (Month) 1916 (Day) (Year)

7. AGE: ..... yrs. ..... mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.? 8

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Moscow Ida

10. NAME OF FATHER Glen A Morton

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Nettie Schumacher

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G A Morton
(Address) Moscow

15. Filed Jan 30 1916 J F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 29th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28th 1916, to Jan 29th 1916, that I last saw her alive on Jan 28th 1916, and that death occurred on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Atelectasis pulmonum

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gutman M. D.
1/30 1916 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Jan 30 1916

20. UNDERTAKER: None | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 1976O

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
(No. ....., ... St.)

File No. 13326
Registered No. 73

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charlie Berglund

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Jan (Month) 1 (Day) 1893 (Year)

7. AGE
23 Yrs. 1 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming at
(b) General nature of industry, business, or establishment in which employed (or employer): his Fathers Home

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Nels Berglund

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Alice Erickson

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Troy Idaho
(Address) Nels Berglund

15. Filed Feb 5 1916
D. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 4th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1916, to Feb. 4th 1916, that I last saw h[illegible] alive on Feb. 4th 1916, and that death occured on the date stated above, at 9:15 P.M.

The CAUSE OF DEATH* was as follows:

Influenza
(Duration) — yrs. 1 mos. 4 ds.
Contributory (Secondary) Acute Endocarditis
(Duration) yrs. 1 mos. 6 ds.

(Signed) J. C. Wirk M. D.
Feb. 5 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Troy Idaho
DATE OF BURIAL 191

20. UNDERTAKER: Glen O Guice
ADDRESS: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

Primary Registration District No. 2141

File No. 13327

Registered No. 12

County of [illegible]

City of near Viola (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Estella Krackey.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: February (Month) 24 (Day) 1895 (Year)

7. AGE: 21 yrs. 11 mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Milliner
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: John Krackey

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. R. Goodrich
(Address) Colfax, Wash.

15. Filed Feb 5 1916 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1916, to Feb 2 1916, that I last saw her alive on Jan. 9. 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pul Tuberculosis of the Lungs

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. E. Patee M. D.

19.... (Address) Pullman Wn

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Removal to Colfax — DATE OF BURIAL: Feb 6 1916

20. UNDERTAKER: L L Bruning — ADDRESS: Colfax Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 13328
Registered No. 11

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ..... Gritmans Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annabal Atchison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
March (Month) 1 (Day) 1870 (Year)

7. AGE
45 Yrs. 10 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Angus McLeod

11. BIRTHPLACE OF FATHER (State or Country): Nova Scotia

12. MAIDEN NAME OF MOTHER: Annabal McLeod ~~Fraser~~

13. BIRTHPLACE OF MOTHER (State or Country): Nova Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward P Atchison
(Address) Kendrick Idaho

15.
Filed Jan 22 1916
D. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January (Month) 19th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 15 1916, to Jan 19 1916, that I last saw her alive on Jan 19 1916, and that death occured on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Rothwell M. D.

Jan 20 1916 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Kendrick Idaho
Former or usual residence Kendrick Idaho

19. PLACE OF BURIAL OR REMOVAL: Kendrick Idaho
DATE OF BURIAL 1916
UNDERTAKER: Allen C Grier
ADDRESS: Moscow

EVANS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13329

Registered No. 3

1. PLACE OF DEATH.

County of Latah

Registration District No. 61

Primary Registration District No. 241

City of 7 miles in Country (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas J. Craft.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 16 (Day) 1847 (Year)

7. AGE: 68 Yrs. ..... Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer Labor

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. A. Rogers

(Address) Moscow

15. Filed Jan 8 1916 W. F. Kerr Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1915, to Jan 1916, that I last saw him alive on about Sept 1915, and that death occured on the date stated above, at 9.20 P.M.

The CAUSE OF DEATH* was as follows:

Valvular insufficiency (Heart)

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Carothers M. D.

Jan 8 1916 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho — DATE OF BURIAL: 1/8 1916

20. UNDERTAKER: [illegible] Grice — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13330

Registered No. 6

Registration District No. 61

Primary Registration District No. 1011

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ..... Lincoln St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Ann Draper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. March (Month) 16 (Day) 1837 (Year)

7. AGE 78 Yrs. 10 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Michigan

10. NAME OF FATHER William Somwell

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Craig

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. L. Draper
(Address) Moscow

15. Filed Jan 27 1916 S. F. Rae Local Registrar

BYRNS-YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1916, to Jan 26 1916, that I last saw her alive on Jan 26 1916, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
..... (Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Old age
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. N. Clarke M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho — DATE OF BURIAL: Jan 28 1916

20. UNDERTAKER: Glen O Price — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13331

Registered No. 7

1. PLACE OF DEATH.

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac A. L. Merrill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 29th (Day) 1840 (Year)

7. AGE: 75 Yrs. 3 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Vermont.

10. NAME OF FATHER: David McKinnon

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. J. Cox

(Address) Moscow Idaho.

15. Filed Jan 24 1916

J. F. Ross
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 13 1914, to Jan 24 1916, that I last saw h[illegible] alive on Jan 23 1916, and that death occured on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Angina pectoris

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) 1 yr. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.

1-24 1916 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 3 mos. 23 days In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho — DATE OF BURIAL: Jan 26 1916

20. UNDERTAKER: Glen O Rice — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & PUBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13332

Registered No. 8

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. 620 South Main St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1611

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Wesley Blacker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
August (Month) 15 (Day) 1854 (Year)

7. AGE
61 Yrs. 5 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Merchant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Augusten Blacker

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Francis J. Sayman

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. A. Blacker
(Address) Everett Wash

15.
Filed Jan 23 1916
D. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan. (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21 1915, to Jan 22 1916, that I last saw h[illegible] alive on Jan 21 1916, and that death occured on the date stated above, at 3:45 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma - Head of Pancreas

(Duration) Yrs. 8 mos. 1 ds.
Not Contributory (Secondary) Laparotomy & Cholecystotomy Done Aug 6th 1915
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John A. Bondd M. D.
1/23 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho
DATE OF BURIAL: Jan 24 1916

20. UNDERTAKER: Glen O. Grice
ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13333

Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Moscow

(No. 610 North Lincoln St.)

Registration District No. 61

Primary Registration District No. 1011

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Draper.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 1 (Day) 1839 (Year)

7. AGE: 76 Yrs. 8 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Twelve Years,

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Benjamin Draper

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Clarke

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. J. Baker
(Address) Moscow, Idaho.

15. Filed Jan 22 1916 E. F. Rae Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 18 1916, to Jan. 20 1916, that I last saw b... alive on ..... 191..., and that death occured on the date stated above, at 1.30 A. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) Yrs. ..... mos. 3 ds.
Contributory (Secondary) old age
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Clarke M. D.
19... (Address) Moscow

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Jan 23 1916

20. UNDERTAKER: Glen O Price — ADDRESS: Moscow

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 13334
Registered No. 10

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (*Write* the word.)

6. DATE OF BIRTH: Apr 28 (Month) (Day) 1855 (Year)

7. AGE: 60 yrs. 8 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Housekeeper

9. BIRTHPLACE (State or Country) N. H.

10. NAME OF FATHER William DeGowri

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Mary DeGowri

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D F Rae
(Address) Moscow

15. Filed Jan 11 1916 D F Rae, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1915, to Jan 11 1916, that I last saw her alive on Jan 10 1916, and that death occurred on the date stated above, at 5:20 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Broncho

(Duration) 2 yrs. mos. 8 ds.
Contributory (Secondary) Lagrippe
(Duration) yrs. mos. ds.

(Signed) D F Rae M. D.
1/11 1916 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Jan 13 1916

20. UNDERTAKER: Glen O Grace | ADDRESS: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 13335
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. County Home St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Pauyne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH.
(Month) (Day) 1 (Year)

7. AGE
77 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Ex Patient
(b) General nature of industry, business, or establishment in which employed (or employer)... Formally Landlady of Restaurant

9. BIRTHPLACE (State or Country) U. S.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Sup A. Frazee
(Address) Veterans Home Moscow I.

15.
Filed Feb 2 1916
D F Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. 1" 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15" 1916, to Feb 1" 1916, that I last saw her alive on Jan 29" 1916, and that death occured on the date stated above, at 1030 A. M.

The CAUSE OF DEATH* was as follows:
Fatty Degeneration of heart.
(Duration) 1 Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) W. T. Carothers M. D.
Feb 2 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow Idaho	Feb 2 1916

20. UNDERTAKER	ADDRESS
Glen O Grice	Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRUS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 67
Primary Registration District No. 1011
File No. 13336
Registered No. 2

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. 226, South Asbury St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Phebe Hutchison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 10 (Day) 1843 (Year)

7. AGE: 72 Yrs. 10 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Short

11. BIRTHPLACE OF FATHER (State or Country): not Known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. B. Buchanan
(Address) Moscow Idaho

15. Filed Feb 4 1916 D. F. Reed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1916, to Feb 3 1916, that I last saw her alive on 2-3 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Myocarditis
(Duration) not Yrs. known mos. ds.
Contributory (Secondary) Tuberculosis Pulm. with Pleurisy
(Duration) yrs. mos. ds.
(Signed) John A Dodd M. D.
2-4-1916 (Address) Moscow

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buchanan Cemetary — DATE OF BURIAL: Feb. 5th 1916

20. UNDERTAKER: Glen O Price — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 170

Primary Registration District No. 799

File No. 13338

Registered No.

County of Cassia

City of Basin (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Catherine E. Lanford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: May 25 1844 (Month) (Day) (Year)

7. AGE: 71 yrs. 8 mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Asher J. Coward

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. A. Lofgren
(Address) Oakley Idaho

15. Filed 1/9 1916 E. P. Oldham Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 5 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1916 to Feb 5 1916, that I last saw h[illegible] alive on Feb 3 1916, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis
Influenza
Broncho Pneumonia

(Duration) — yrs. — mos. 4 ds.

Contributory (Secondary) Myocarditis

(Duration) 5 yrs. — mos. ..... ds.

(Signed) E. P. Oldham M. D.

2/9 1916 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Basin

DATE OF BURIAL: 2-7 1916

20. UNDERTAKER: A. Sayer

ADDRESS: Basin Idaho

Ment. of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126
Primary Registration District No. 2204
(No. ..... St.)

File No. 13339
Registered No. 2

1. PLACE OF DEATH.
County of Kootenai
City of Harrison

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Robin Gardner

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Nov (Month) 6 (Day) 1913 (Year)
7. AGE: Yrs. 2 Mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Harrison Ida.
10. NAME OF FATHER: Roy Gardner.
11. BIRTHPLACE OF FATHER (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Ethel Osborn.
13. BIRTHPLACE OF MOTHER (State or Country): Ind.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Roy Gardner
(Address) Harrison Ida
15. Filed Feb 7 1916 R. S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 16th Jan 1916 to 16th Jan 1916, that I last saw h-r alive on Jan 16th 1916, and that death occured on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Double Pneumonia.
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Freeman M. D.
1-17 1916 (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison Ida — DATE OF BURIAL: 1-17 1916
20. UNDERTAKER: Evans Hdw. — ADDRESS: Harrison

SYMS - YORK CO., PTRS. & ENGS. 24659

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 126

Primary Registration District No. 2204

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13340

Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Harrison

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howard Fredrick Osborn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. April 28 1913 (Month) (Day) (Year)

7. AGE 2 Yrs. 9 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Harrison

10. NAME OF FATHER Elmer Osborn

11. BIRTHPLACE OF FATHER (State or Country) Ind

12. MAIDEN NAME OF MOTHER Edith Hazelwood

13. BIRTHPLACE OF MOTHER (State or Country) Tex

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmer Osborn

(Address) Harrison Ida.

15. Filed Feb 7 1916 R. S. Gradon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 31 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1916, to Jan 31 1916, that I last saw h- alive on Jan 31 1916, and that death occured on the date stated above, at 2.50 P.M.

The CAUSE OF DEATH* was as follows: Pneumonia Broncho

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ben Turner M. D.

2-1 1916 (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Harrison — **DATE OF BURIAL** 2-1 1916

20. UNDERTAKER — **ADDRESS**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 12
Primary Registration District No. 2204
(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13341
Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Kootenai
City of Harrison

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Mitchell McCloskey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 21 (Day) 1915 (Year)

7. AGE: .....Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: L.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Wm J McCloskie

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: Edith Brighton

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J W McCloskey
(Address) Harrison Ida

15. Filed Feb 7 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1916, to Jan 23 1916, that I last saw h— alive on Jan 23 1916, and that death occured on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) .....Yrs. .....mos. 2 ds.
Contributory (Secondary)
(Duration .....yrs. .....mos. .....ds.

(Signed) J W Closkey M. D.
1-23 1916 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison Cem — DATE OF BURIAL: 1/24 1916

20. UNDERTAKER: Snow Reeder — ADDRESS: Harrison

SYMS - YORK CO., PTRS. & BDRS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 126

Primary Registration District No. 2209

File No. 13342

Registered No. 1

County of Kootenai

City of Harrison. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W. J. Thompson,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: October (Month) Eleventh (Day) 1839 (Year)

7. AGE: 76 yrs. 2 mos. 27 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Nathaniel Thompson

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Mary Jones

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. Mae Gilbert (Daughter)

(Address) Harrison, Idaho.

15. Filed Feb 7 1916 R. S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) Seventh (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 15 1915, to Jan. 7th 1916, that I last saw him alive on Nov. 3rd 1915 and that death occurred on the date stated above, at 10.15 M.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) yrs. 10 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Didier, M. D.

Jan 7 1916 (Address) Harrison, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Harrison Cemetery

DATE OF BURIAL: Jan. 8th 1916

20. UNDERTAKER: E.W. Wheeler E. W. Wheeler

ADDRESS: Harrison

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Kendrick
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No. 2143
(No. ..... St.)

File No. 13343
Registered No. 26
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Arved Aas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: January 4. 1916 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 8 ds.
IF LESS than 1 day how many 12 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Kendrick Idaho

10. NAME OF FATHER: Zacharias Aas

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Caroline Lien

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Zacharias Aas
(Address) Kendrick Ida. R. x 2

15.
Filed Jan 13 1916 J. E. Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 13 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 4 1916 to Jan 13 1916
that I last saw him alive on Jan 6th 1916
and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Unoperable Spina Befida

(Duration) ..... yrs. ..... mos. 8½ ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Rothwate M. D.
Jan 13 1916 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Norwegian Cemetery
DATE OF BURIAL: Jan 15 1916

20. UNDERTAKER: none
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13344

Registered No. 19

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Latah
City of Kendrick

Registration District No. 63
Primary Registration District No. 2143
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gjetrud Westgaard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: January (Month) 7 (Day) 1825 (Year)

7. AGE: 91 yrs. ..... mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Gjetrud Lien

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. H. Forest
(Address) Kendrick Idaho

15.
Filed Jan 29 1916 J. E. Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1915, to Jan 25 1916
that I last saw h[illegible] alive on Jan 25 1916
and that death occurred on the date stated above, at 3 A M.
The CAUSE OF DEATH* was as follows:

L. Grippe

..... (Duration) ..... yrs. ..... mos. 6 ds.
Contributory (Secondary) Debility of old age
..... (Duration) 5 1 yrs. ..... mos. ..... ds.

(Signed) W. A. Northcutt M. D.
Jan 29 1916 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Norwegian Lutheran Cemetery at Bethany Church Latah Co
DATE OF BURIAL: Jan 31. 1916

20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of
City of
(No. , St.)

Registration District No. 63
Primary Registration District No. 2143

File No. 13345
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Faith Foster

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 1st (Day) 1901 (Year)

7. AGE: 14 yrs. 7 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Ira E Foster

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Mary Alice Smith

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ira E Foster
(Address) Linden Idaho

15. Filed Feb 7 1916 J E Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 27. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20th 1916, to Jan 27th 1916 that I last saw h[illegible] alive on Jan 26th 1916 and that death occurred on the date stated above, at 12 A M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. G. Rothwell M. D.

Jan 30th 1916 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Southwick
DATE OF BURIAL: Jan 30 1916

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 63
County of Latah, Primary Registration District No. 2143
City of Nr. Kendrick Ida (No. ....., ... St.)
File No. 13346
Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Hecht

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Feb. (Month) 2. (Day) 1846 (Year)

7. AGE: 69 yrs. 11 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: William Hecht

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Hecht
(Address) Kendrick Idaho

15. Filed Feb 7 1916 J E Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Found dead in bed no doctor
viewed by Coroner

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Well Bon cemetery Latah Co. Idaho.
DATE OF BURIAL: Jan 26. 1916

20. UNDERTAKER: Elmer Beebtol
ADDRESS: Kendrick Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13347
Registered No. 2

1. PLACE OF DEATH.
County of Lewis
City of Russell Idah

Registration District No. 47
Primary Registration District No. 2124
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Not Named

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan. 1 (Month) Jan 10 (Day) 1916 (Year)

7. AGE: 0 yrs. Jan mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION: None
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Russell Lewis Co Idaho.

10. NAME OF FATHER: Emel Krauen

11. BIRTHPLACE OF FATHER (State or Country): Germana

12. MAIDEN NAME OF MOTHER: Helen Krubaback

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Shawley
(Address) Key Perce Idaho.

15. Filed ..... 191...
W. F. McMahon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 11 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from At Birth 1916, to Jan 11 1916 that I last saw her alive on At Birth 1916 and that death occurred on the date stated above, at P M.

The CAUSE OF DEATH* was as follows:
Hydro Cephalus

0 (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Shawley M D M. D.
1-12 1916 (Address) Russell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place Russell Idaho In the Co of Lewis
of death 0 yrs. ..... mos. ..... ds. State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Russell Idaho
DATE OF BURIAL: Jan 11 1916

20. UNDERTAKER: Hard
ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13348
Registered No. 1

1. PLACE OF DEATH. Registration District No. 47
County of Ada Primary Registration District No. 2124
City of Meridian (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Jane Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 3 (Day) 1854 (Year)

7. AGE: 61 yrs. 2 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: George Smith

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Wonders

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Harrison
(Address) Meridian Idaho

15. Filed 1-6 1916 J. F. Jones, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1912, to Jan 20 1915 that I last saw h[illegible] alive on Jan 20 1915 and that death occurred on the date stated above, at 10 9. M.

The CAUSE OF DEATH* was as follows:
Endocarditis (mitral stenosis) & pneumonia
(Duration) several yrs. mos. ds.
Contributory Rheumatism
(Secondary)
(Duration) several yrs. mos. ds.
(Signed) O. A. Jeffreys M. D.
1-6 1916 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Afton Iowa — DATE OF BURIAL: Jan. 1916

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE. 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1 13349

Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood

Registration District No. 105
Primary Registration District No. 2183
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christian Lange

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feby (Month) 29 (Day) 1844 (Year)

7. AGE: 71 yrs. 10 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work. Retired Farmer
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. C. Lange
(Address) Cottonwood, Ida.

15.
Filed Jany 9th 1916 W. H. Baker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 8th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3d 1916, to Jan 8th 1916
that I last saw h im alive on Jan 7 1916
and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Senile Dementia
..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) J. A. Shinnick M. D.
Jan 9 1916 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood
DATE OF BURIAL: Jan 10 1916

20. UNDERTAKER: A. J. Maugg
ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13350
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Ferdinand

Registration District No. 105
Primary Registration District No. 2183
(No. Ferdinand St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josie Aschenbrenner.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH: April 4 1894. (Month) (Day) (Year)

7. AGE: 21 yrs. 9 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Joseph Fredrick.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Rosie Lusk.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jos. A. Aschenbrenner
(Address) Ferdinand Ida.

15.
Filed Jany 13 1916 W. W. Blake Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. 12 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1916, to Jan 12 1916
that I last saw h[illegible] alive on Jan 12 1916
and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:
Cerebral Convulsions
probable cause Effect
Cause difficult to State
(Duration) — yrs. mos. one ds.

Contributory (Secondary): not known
(Duration) yrs. mos. ds.

(Signed) Russell Truitt M. D.
Jan 12 1916 (Address) Ferdinand Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cottonwood — DATE OF BURIAL: Jan 14 1916

20. UNDERTAKER: J. Mauger — ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3 13351
Registered No.....

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood

Registration District No. 105
Primary Registration District No. 2183
(No....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Etta Fredericke

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Twenty Second July 1913 (Month) (Day) (Year)
7. AGE: 2 yrs. 6 mos. 1 ds. IF LESS than 1 day how many.....hrs. or .....min.
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): Cottonwood Idaho
10. NAME OF FATHER: C. E. Fredericks
11. BIRTHPLACE OF FATHER (State or Country): Karney Nebr
12. MAIDEN NAME OF MOTHER: Bessie Downer
13. BIRTHPLACE OF MOTHER (State or Country): Davis Jct. Ill
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. A. Downer
(Address) Cottonwood Idaho
15.
Filed Jan 24 1916 H. Bogle Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1st (Month) 23 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1916, to Jan 23 1916
that I last saw her alive on Jan 23 1916
and that death occurred on the date stated above, at 8 A. M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. D. Steinmetz M. D.
Jan 23 1916 (Address) Cottonwood Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood
DATE OF BURIAL: Jan 24 1916
20. UNDERTAKER: A. J. Maugg
ADDRESS: Cottonwood

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 13352
Registered No. 5

1. PLACE OF DEATH.
County of Cassia
City of Jackson
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edna O Creasor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. [redacted] (Month) 17 (Day) 1886 (Year)

7. AGE: 29 Yrs. 3 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mo

10. NAME OF FATHER Geo Rutledge

11. BIRTHPLACE OF FATHER (State or Country) Ill Tenn

12. MAIDEN NAME OF MOTHER Jasie Rutledge

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Percy Rutledge
(Address) Jackson

15. Filed 2-7 1916 E. H. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1916, to Jan 22 1916, that I last saw h-- alive on Jan 22 1916, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Puerperal Peritonitis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. H. Elmore M. D.
2-7 1916 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: 1-25 1916

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 13358
Registered No. 109

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alma Laurence Henderson.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Exact age unknown. (Month) (Day) 1887 (Year)

7. AGE
28 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Franklin Co- Ida.

10. NAME OF FATHER
Aaron Henderson.

11. BIRTHPLACE OF FATHER
(State or Country) Weber Co. Utah

12. MAIDEN NAME OF MOTHER
Harriet VanLauwen

13. BIRTHPLACE OF MOTHER
(State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. Henderson
(Address) Clifton Ida

15.
Filed Jan 20 1916 Dr. J. C. Patterson
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7 PM Jan. 19 1916, to 11-30 PM Jan. 19 1916, that I last saw him alive on Jan 19 1916, and that death occured on the date stated above, at 11-30 P.M.

The CAUSE OF DEATH* was as follows:
Struck on head with lump of Coal.
Accidental.

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Hemorrhage from concussion of brain (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr. S. E. Cramer M. D.
Jan 21 1916 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clifton Ida
DATE OF BURIAL: Jan 23 1916

20. UNDERTAKER: L. B. Colegrove
ADDRESS: Burley Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia

City of Burley Ida

(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 17

Primary Registration District No. 2196

(No. ..... St.)

File No. 13361

Registered No. 112

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Jane Allred

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Feby (Day) 22 (Year) 1859

7. AGE: Yrs. 57 Mos. 11 ds. 0

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa

10. NAME OF FATHER: George Williams

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W Allred

(Address) Burley Ida

15.

Filed Jan 23rd 1916. Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) Jany (Day) 22 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st 1915, to Jan. 22nd 1916, that I last saw h[illegible] alive on Jan 22 1916, and that death occured on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) Several Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) J. C. Patterson M. D.

Jan 24 1916. (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley, Ida.

DATE OF BURIAL: Jan. 24th 1916.

20. UNDERTAKER: R. W. Watt

ADDRESS: Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13362

Registered No. 14

1. PLACE OF DEATH.

County of Canyon

City of Caldwell, Rural (No. ..... St.)

Registration District No. 3

Primary Registration District No. 2005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Nishinota

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Jap.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Feb (Month) 3 (Day) 1916 (Year)

7. AGE: .....Yrs. .....Mos. 3 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Caldwell Idaho

10. NAME OF FATHER: Jugiro Nishinota

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Roku Takata

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jugiro Nishinota

(Address) Caldwell Idaho

15.

Filed 2-8- 1916 John D. Myers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h.....alive on ..... 191...,
and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Natural Causes

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) A. A. Farris Coroner

2/8 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nampa. Idaho. DATE OF BURIAL: 2-9-1916

20. UNDERTAKER: W C Dyer ADDRESS: Idaho Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 3

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13363

Registered No. 5

Registration District No.

Primary Registration District No. 2005

1. PLACE OF DEATH.

County of Canyon

City of Caldwell (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Judson F. Allen.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 18 (Day) 1881 (Year)

7. AGE: 33 Yrs. — Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Minnesota

10. NAME OF FATHER Kinsley F. Allen

11. BIRTHPLACE OF FATHER (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Julia P. Randall

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Judson F. Allen
(Address) Caldwell Ida

15. Filed 1-10-1916 John J. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1915, to Jan 7 1916, that I last saw him alive on Jan 7 1916, and that death occured on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
Peritonitis,

(Duration) Yrs. mos. 4 ds.
Contributory (Secondary) Typhoid fever

(Duration yrs. mos. 26 ds.

(Signed) [illegible] M. D.
1/8 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: Jan 10 1916

20. UNDERTAKER: Beckham Co Co ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 13364
Registered No. 6

1. PLACE OF DEATH.
County of Canyon
City of Middleton
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Matilda Jackson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Oct. (Month) 12 (Day) 1858 (Year)

7. AGE
57 Yrs. 2 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Salt Lake Co. Utah

10. NAME OF FATHER
George Gates

11. BIRTHPLACE OF FATHER
(State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER
Mariah Liveriedge

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Marion Jackson
(Address) Middleton Idaho

15.
Filed 1-12- 1916
John P. Meyer
Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from She was dead when seen 191..., to ..... 191...., that I last saw h..... alive on ..... 191...., and that death occured on the date stated above, at 12 noon M.

The CAUSE OF DEATH* was as follows:
Paralysis of lower extremities and acute Indigestion

(Duration) — Yrs. 1 mos. — ds.

Contributory (Secondary)
(Duration — yrs. 1 mos. — ds.

(Signed) J. W. Hamer M. D.
1/9 1916 (Address) Middleton Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Middleton Cemetery
DATE OF BURIAL: 1-13 1916

20. UNDERTAKER: W. L. Dyer
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. ....., ... St.)

File No. 13365
Registered No. /

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl Turman Dustiman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 26 (Day) 1898 (Year)

7. AGE: 17 Yrs. 6 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Red Oak, Iowa

10. NAME OF FATHER Seymour Dustiman

11. BIRTHPLACE OF FATHER (State or Country) Alliance Ohio.

12. MAIDEN NAME OF MOTHER [illegible] Jague

13. BIRTHPLACE OF MOTHER (State or Country) Glenwood Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Dustiman
(Address) Caldwell

15.
Filed 1-10-1916
John L. Meyer
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidental Gun shot
by his own hand
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) A. A. Faris - Coroner Canyon Co. M. D.
Jan 9 1916 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 1/10 1916

20. UNDERTAKER: W. E. Dyer
ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13366
Registered No. 8

Registration District No. 3
Primary Registration District No. 1005
(No. ....., ... St.)

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jean Westcott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan. (Month) 27 (Day) 1876 (Year)

7. AGE: 29 Yrs. 11 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Arthur S. Gaukins

11. BIRTHPLACE OF FATHER (State or Country): United States

12. MAIDEN NAME OF MOTHER: Belle S. Smith

13. BIRTHPLACE OF MOTHER (State or Country): United States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. J. Westcott
(Address) Caldwell, Idaho.

15. Filed Jan. 17 1916 John L. Meyers, Local Registrar

BYNS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1916, to Jan 16 1916, that I last saw h[illegible] alive on Jan 16 1916 and that death occured on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia, Following Influenza
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. R. Cole M. D.
1/17 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Sioux City Iowa
DATE OF BURIAL: 1/17 1916

20. UNDERTAKER: W. C. Dyer
ADDRESS: Caldwell.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2004

File No. 13368

Registered No. 198

County of Owyhee

City of Rural (Caldwell (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Hunnicutthouse

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (October) (24th) 1863
(Month) (Day) (Year)

7. AGE: 57 Yrs. 2 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maryland

10. NAME OF FATHER: Geo Hunnicutthouse

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna Mist

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John M. Hunnicutthouse
(Address) Catonia Ida

15.
Filed 1-18- 1916
Jos. S. Hayes
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan. (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Natural causes- Apoplexy
Heart disease.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. A. Faris acting Coroner M. D.
1/19/1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell — DATE OF BURIAL: Jan 19 1916

20. UNDERTAKER: W. C. Dyer — ADDRESS: Caldwell Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 13369
Registered No. 11

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis M. Parrish

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH. Jan (Month) 7 (Day) 1863 (Year)

7. AGE: 53 Yrs. — Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: W. H. Parrish

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Ann Williams

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. W. H. Parrish
(Address) Ustick Idaho

15. Filed 1-21-1916 John S. Brewer Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1916, to Jan 21 1916, that I last saw him alive on Jan 20 1916, and that death occured on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:
Tuberculosis
(Duration) 6 Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) H. J. Miller M. D.
1-21-1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Jan 22 1916

20. UNDERTAKER: W. E. Dyer — ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13370

Registered No. 12

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patrick John Downey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. About — (Month) — (Day) 1855 (Year)

7. AGE About 60 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Janitor

9. BIRTHPLACE (State or Country): New Hampshire

10. NAME OF FATHER: Do not Know

11. BIRTHPLACE OF FATHER (State or Country): Do not Know

12. MAIDEN NAME OF MOTHER: Do not Know

13. BIRTHPLACE OF MOTHER (State or Country): Do not Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. A. Morehead.

(Address) Caldwell Idaho.

15. Filed 1-25- 1916

Jas. S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 28" 1915, to Jan. 24" 1916, that I last saw h[illegible] alive on Jan. 23" 1916, and that death occured on the date stated above, at 1. P. M.

The CAUSE OF DEATH* was as follows:

"Lagrippe".

(Duration) ..... Yrs. 1 mos. 26 ds.

Contributory (Secondary) General debility resulting from abscess.

(Duration ..... yrs. 1 mos. ..... ds.

(Signed) J. M. Henry M. D.

Jan 25 1916. (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 1/25 1916

20. UNDERTAKER: W. E. Dyer — ADDRESS: Caldwell.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13371

Registered No. 573.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Caldwell Rural

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Morrice Bird Bowman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 16 (Day) 1843 (Year)

7. AGE: 72 Yrs. 1 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Tenn.

10. NAME OF FATHER Joseph Bowman

11. BIRTHPLACE OF FATHER (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Honor Newman

13. BIRTHPLACE OF MOTHER (State or Country) Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lerte Bowman

(Address) Caldwell R#2

15.

Filed 1-27-1916

John P. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 5" 1915, to Jan 26" 1916, that I last saw him alive on Dec. 16" 1915, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cancerous of Stomach.

(Duration) One Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Henry M. D.

1/27/1916. (Address) Caldwell Idaho.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Ridge

DATE OF BURIAL: 1/28 1916

20. UNDERTAKER: W. E. Dyer

ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

Primary Registration District No. 2184

File No. 13372

County of Idaho

City of Kooskia (No. ....., ... St.)

Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Karl Thenon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 30 (Day) 1913 (Year)

7. AGE: 3 Yrs. 7 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Edward C. Thenon

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Rosie Gray

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Martha Gray
(Address) Kooskia

15. Filed Jan 17 1916 J.M. Verbeckmus Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1915, to Jan 16 1916, that I last saw him alive on Jan 16 1916, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Influenza

..... (Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary) Broncho pneumonia

..... (Duration ..... yrs. ..... mos. 3 ds.

(Signed) J.M. Verbeckmus M. D.

Jan 16 1916. (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kooskia Cemetery — DATE OF BURIAL: Jan 18 1916

20. UNDERTAKER: Tenney & Merchant — ADDRESS: Kooskia Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho
City of Kooskia
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 106
Primary Registration District No. 2184
(No. ....., ... St.)

File No. 13373
Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edwin Ernest Kidder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. June (Month) 26 (Day) 1873 (Year)
7. AGE: 42 Yrs. 6 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Wisconsin
10. NAME OF FATHER John W. Kidder
11. BIRTHPLACE OF FATHER (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Martha Wilkie
13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. Wilgress
(Address) Kooskia Idaho
15. Filed Jan 10 1916 J.M. Verbeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 9 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1915, to Jan 9 1916, that I last saw him alive on Jan 7 1916, and that death occured on the date stated above, at 7 P M.
The CAUSE OF DEATH* was as follows:
Diabetis Mellitus
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) J.M. Verbeck M. D.
Jan 9 1916 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kooskia Cemetery — DATE OF BURIAL: Jan 11 1916
20. UNDERTAKER: Freeman & Merchant — ADDRESS: Kooskia Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

Primary Registration District No. 2184

File No. 13324

County of Idaho

City of Kooskia (No. ....., ... St.)

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Timothy Dunlap

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

May (Month) 18 (Day) 1837 (Year)

7. AGE

78 yrs. 7 mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Stonemason

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Cornelius Dunlap

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Margaret Fagan

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. R. Quinlan

(Address) Kooskia - Idaho

15.

Filed Jan 9 1916 J. M. Vulbertson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h[illegible] alive on Dec 20 1915,

and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Cancer of face and neck

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Wohlenberg M. D.
R. M. Vital Statistics

Jan 9 1916 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pendelton - Oregon	191...

20. UNDERTAKER	ADDRESS
Freeman & Merchant	Kooskia Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13375

Registered No. 2

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 34

County of Elmore Primary Registration District No. 2020

City of Mountain Home Ida (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Aurelia Gorlitz Fitzpiva[illegible]

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1859 (Year)

7. AGE: 56 yrs. 10 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Maryland

10. NAME OF FATHER: Jacob Gorlitz

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: Liddie Griffith

13. BIRTHPLACE OF MOTHER (State or Country): Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Isaac J Fitzwater
(Address) Mountain Home

15. Filed Jan 15th 1916 B Worthington Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Instant yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H H Easton Co. Coroner M. D.
1/15 1916 (Address) Mtn Home Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Idaho
DATE OF BURIAL: Jan 16th 1916

20. UNDERTAKER: J M Cowen
ADDRESS: Mtn Home Ida

BYRNS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Elmore — Registration District No. 34
City of Mountain Home (No. ....., ... St.) — Primary Registration District No. 2020
File No. 13376
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Caroline Jacobson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: January (Month) 5th (Day) 1848 (Year)

7. AGE: 68 yrs. — mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Andrew Nelson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Caroline Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Jacobson
(Address) Mountain Home

15. Filed Jan. 17 1916 — B. O. Mather, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 6th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 22nd 1915, to Jan. 4th 1916, that I last saw her alive on Jan. 4th 1916, and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of pancreas - unknown
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary): auto-intoxication
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) B. O. Mather M. D.
1/4 1916 (Address) Mtn Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Idaho — DATE OF BURIAL: Jan. 9th 1916

20. UNDERTAKER: J. M. Cowan — ADDRESS: Mountain Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Fremont
City of Parker
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2177
(No. ....., ... St.)

File No. 13381
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Rosie Larsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Divorced

6. DATE OF BIRTH: Not Known (Month) (Day) 1866 (Year)

7. AGE: 50 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas Jennings

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lena A. Larsen Watson
(Address) Parker Idaho

15. Filed Jan 31 1916 W D Clark Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 29 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1916, to Jan 29 1916, that I last saw her alive on Jan 27 1916 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Mania a Potu
.....
.....
(Duration) ..... yrs. 4 mos. ..... ds.
Contributory Chronic Nephritis
(Secondary)
(Duration) ..... yrs. 4 mos. 4 ds.

(Signed) W D Clark M. D.
Jan 31 1916 (Address) St Anthony Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Drake Utah | DATE OF BURIAL: Feby 2 1916

20. UNDERTAKER: W D Mayer | ADDRESS: St Anthony Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 99

Primary Registration District No. 5177

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13382

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lorenzo Bond.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1906 (Year)

7. AGE: 70 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): .....

10. NAME OF FATHER: S. A. Bond

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Lizzie Mapes

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. E. Boucher
(Address) .....

15. Filed 1/15 1915 W. D. Weed Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/14 1916, to 1/14 1916, that I last saw h[illegible] alive on 1/14 1916 and that death occured on the date stated above, at 2.05 P. M.

The CAUSE OF DEATH* was as follows:

Diphtheria

..... (Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary): none

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. E. Boucher M. D.

1/15 1915 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Teton — DATE OF BURIAL: 1/15 1916

20. UNDERTAKER: W. J. Hayes — ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13383

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of Egin

If death occurred away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 2177

(No. ....., ... St.)

2. FULL NAME Violet Hyatt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Jan (Month) 11 (Day) 1916 (Year)

7. AGE: 27 Yrs. 0 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: A. Anderson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Emma Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Geo. Hyatt

(Address) Egin Ida

15. Filed Jan 10 1916 W. Ward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/4 1915, to 1/8 1916, that I last saw her alive on 1/8 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) Yrs. 8 mos. 0 ds.

Contributory (Secondary) Confinement

(Duration yrs. mos. ds.

(Signed) F. W. Bruchen M. D.

1/22 1916 (Address) Dr Dunlavy

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191.....

20. UNDERTAKER: None | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13384

Registered No.

1. PLACE OF DEATH. Registration District No. 99

County of Bingham Primary Registration District No. 2177

City of St Anthony, Ida (If not in incorporated territory give township) No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac Harris Parker

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Married

6. DATE OF BIRTH Dec 13 1885
(Month) (Day) (Year)

7. AGE 30 yrs. 11 mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work Farming
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Isaac Harris Parker

11. BIRTHPLACE OF FATHER (State or Country) Nevada

12. MAIDEN NAME OF MOTHER Hannah Dorsey

13. BIRTHPLACE OF MOTHER (State or Country) Australia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W Brent
(Address) St Anthony

15. Filed Jan 10 1916 W Brent Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 6 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1916, to Jan 5 1916 that I last saw him alive on Jan 3 1916 and that death occurred on the date stated above, at 7-9 M.

The CAUSE OF DEATH* was as follows: Gun shot wound through chest

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W Brent M. D.
Jan 6 1916 (Address) St Anthony

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Milford DATE OF BURIAL Jan 8 1916

20. UNDERTAKER None ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2046
File No. 13385
Registered No. 12

1. PLACE OF DEATH.
County of Bannock
City of Downey
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Lee Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Jan 22 (Month) (Day) 1916 (Year)

7. AGE: ....Yrs. ....Mos. 3 Dys. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Downey Idaho

10. NAME OF FATHER: Dan J. Phillips

11. BIRTHPLACE OF FATHER (State or Country): Downey

12. MAIDEN NAME OF MOTHER: Rebecca Ware

13. BIRTHPLACE OF MOTHER (State or Country): Downey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Evans.
(Address) Downey

15. Filed Feb 10, 1916 Ellis Kunz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 22 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1916, to Jan 26 1916, that I last saw him alive on Jan 22 1916, and that death occured on the date stated above, at 10 a M.
The CAUSE OF DEATH* was as follows:
Fetal asphyxia
(Duration) ....Yrs. ....mos. 4 ds.
Contributory (Secondary)
(Duration ....yrs. ....mos. ....ds.
(Signed) Carl W Ware M. D.
19.... (Address) Downey Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Downey — DATE OF BURIAL: Jan 22 1916

20. UNDERTAKER: Evans. — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13387

Registered No. 13

Registration District No. 11

Primary Registration District No. 2048

(No. ..... St.)

1. PLACE OF DEATH.

County of Bannock

City of Bancroft

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eugenia Rigby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. April (Month) 28 (Day) 1856 (Year)

7. AGE: 59 Yrs. 9 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Chas Dunn

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Margaret Cook

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Rigby
(Address) Bancroft Ida.

15. Filed Feb 10 1916 Chas A Carley Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1915, to Feb 1, 1916, that I last saw her alive on Jan 9, 1916, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Organic Heart Disease
.....
.....
.....(Duration) 0 Yrs. 1 mos. ..... ds.

Contributory (Secondary) Chronic Rheumatism
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas A Carley M. D.
Feb 10 1916 (Address) Bancroft Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bancroft, Utah — DATE OF BURIAL: Feb 5 1916

20. UNDERTAKER: Simmons & Hart — ADDRESS: Bancroft

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2048
(No. ..... St.)

File No. 13388
Registered No. 14

1. PLACE OF DEATH.
County of Bannock
City of Grace
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Landerman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Aug (Day) 14 (Year) 1908

7. AGE: 7 Yrs. 5 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ogden, Utah

10. NAME OF FATHER: Peter Landerman

11. BIRTHPLACE OF FATHER (State or Country): Holland

12. MAIDEN NAME OF MOTHER: Margaret Rayhoor

13. BIRTHPLACE OF MOTHER (State or Country): Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Peter Landerman
(Address) Grace, Ida

15. Filed Feb 10 1916 Ellis Kaye
Local Registrar

SVMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) Jan (Day) 14 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1916, to Jan 16 1916, that I last saw him alive on Jan 15 1916, and that death occured on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:
Meningitis

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Mastoid Abscess
(Duration ..... yrs. ..... mos. 6 ds.

(Signed) Ellis Kaye M. D.
Feb 10 1916 (Address) Soda Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grace
DATE OF BURIAL: Jan 22 1916

20. UNDERTAKER: None
ADDRESS: —

Form V. S. No. 5—10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Ares
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59
Primary Registration District No. 239
(No. ....., ... St.)

File No. 4399
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Raymond Edward Meacham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Dec 16 1915 (Month) (Day) (Year)
7. AGE: ..... yrs. ..... mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, professsion, or particular kind of work: —
(b) General nature of industry business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Ares, Idaho
10. NAME OF FATHER: Charles Henry Meacham
11. BIRTHPLACE OF FATHER (State or Country): Farmington, Utah
12. MAIDEN NAME OF MOTHER: Minnie Ellen Babbitt
13. BIRTHPLACE OF MOTHER (State or Country): Alba Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Meacham
(Address) Ares, Idaho
15.
Filed Jan 10 1916 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 8 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916, to Jan 8 1916 that I last saw h in alive on Jan 8 1916, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
Jan 8 1916 (Address) Ares, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moore Idaho — DATE OF BURIAL: Jan 10 1916
20. UNDERTAKER: Chas Meacham — ADDRESS: Ares, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 39

Primary Registration District No. 2137

File No. 44

Registered No. 13391

County of Blaine

City of Arco (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Toland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 29 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... —

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Arco, Idaho

10. NAME OF FATHER Rolland Toland

11. BIRTHPLACE OF FATHER (State or Country) Michigan

12. MAIDEN NAME OF MOTHER Maud Hurwell

13. BIRTHPLACE OF MOTHER (State or Country) Blackfoot Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rolland Toland

(Address) Arco, Idaho

15. Filed Jan 25 1916 Ewfor Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1916, to Jan 23 1916, that I last saw her alive on Jan 23 1916, and that death occured on the date stated above, at 1:29 M.

The CAUSE OF DEATH* was as follows:

Atelectasis

4 hrs

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ewfor M. D.

1/23 1916 (Address) Arco, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arco, Idaho — DATE OF BURIAL: 1/25 1916

20. UNDERTAKER: Rolland Toland — ADDRESS: Arco Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNUM-YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 59
County of Blaine Primary Registration District No. 2139
City of Arco (No. ....., ... St.)
File No. 43392
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ..... Belnap

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 15 (Day) 1915 (Year)

7. AGE: ..... yrs. ..... mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Arco, Idaho

10. NAME OF FATHER: Linsey Belnap

11. BIRTHPLACE OF FATHER (State or Country): Salem Idaho

12. MAIDEN NAME OF MOTHER: Elma Louis Baker

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Linsey Belnap
(Address) Arco Idaho

15.
Filed Jan 2 1916 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1915, to Jan 2 1916
that I last saw h.. alive on Jan 2 1916
and that death occurred on the date stated above, at 12 P M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Congenital Goitre enormous
(Duration) ..... yrs. ..... mos. 17 ds.
(Signed) ..... M. D.
Jan 2 1916 (Address) Arco, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arco Idaho — DATE OF BURIAL: Jan 4 1916

20. UNDERTAKER: Louis Hahn — ADDRESS: Arco, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2139
File No. 19393
Registered No.

1. PLACE OF DEATH.
County of Blaine
City of Clyde
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME George Campbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan 5 (Month) 1848 (Day) (Year)

7. AGE: 68 yrs. mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Troy, New York

10. NAME OF FATHER: Patrick Campbell

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Ann Campbell

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Campbell
(Address) Ansell, Mass

15.
Filed Jan 5 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1916, to Jan 3 1916, that I last saw h[illegible] alive on Jan 3 1916, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Arteris Sclerosis

(Duration) Months yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
Jan 6 1916. (Address) Clyde Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clyde Idaho | DATE OF BURIAL: Jan 5 1916

20. UNDERTAKER: Robert Williams | ADDRESS: Clyde, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lewis
City of Winchester (No. ....., ... St.)

Registration District No. 48
Primary Registration District No. 21a7

File No. 13396
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samantha Ellis

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: March 28th 1846 (Month) (Day) (Year)

7. AGE: 69 yrs. 9 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Erie Co Penna

10. NAME OF FATHER: Symus Fowler

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: Elizabeth Rogers

13. BIRTHPLACE OF MOTHER (State or Country): Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. J. Ellis
(Address) Winchester

15. Filed 1-11 1916 Elbert B. Rogers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January 11th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1912, to January 11th 1916 that I last saw her alive on January 9th 1916 and that death occurred on the date stated above, at 8.4 M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elbert B. Rogers M. D.
1-11- 1916 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: 1-12-1916

20. UNDERTAKER: H. R. Meichert — ADDRESS: Clarkston Wash

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Roberts
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. ..... St.)

File No. 13401
Registered No. 48
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Gilbert Furtchell.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	Single

6. DATE OF BIRTH
April (Month) 7th (Day) 1892 (Year)

7. AGE
23 yrs. 9 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Blackfoot, Idaho

10. NAME OF FATHER Wm Furtchell

11. BIRTHPLACE OF FATHER (State or Country) Salt Lake City, Utah

12. MAIDEN NAME OF MOTHER Emma Jennett

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. C. Furtchell
(Address) Blackfoot, Ida.

15.
Filed Feb 10 1916 Ray H. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January (Month) 24th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1916, to Jan 24 1916, that I last saw him alive on Jan 24 1916, and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Gun shot wound of chest. Self inflected. Accidental

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earl D. Jones M. D.
Jan 24 1916. (Address) Roberts, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Removed to Idaho Falls Ida — DATE OF BURIAL ..... 191..

20. UNDERTAKER 4-24-16. — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32

Primary Registration District No. 2049

File No. 13406

Registered No. .....

1. PLACE OF DEATH.

County of Bennah

City of St. Maries (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Magnet Stone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 28 (Day) 1915 (Year)

7. AGE: ..... Yrs. 7 Mos. 8 ds. 6

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) St Maries, Idaho

10. NAME OF FATHER Gust Stone

11. BIRTHPLACE OF FATHER (State or Country) Boda Wgrmland Sweden

12. MAIDEN NAME OF MOTHER Mary Olson

13. BIRTHPLACE OF MOTHER (State or Country) Brunsnäs pr Warmland pro Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gust Stone

(Address) St maries Idaho

15. Filed Jan. 4 1916 K. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 3 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916 to Jan 3 1916, that I last saw h[illegible] alive on Jan 3 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. Cornwall M. D.

1/4 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL St. Maries Idaho — DATE OF BURIAL Jan 5 1916

20. UNDERTAKER K. L. Mulcahy — ADDRESS St Maries

SYMS - YORK CO., PTRS. & BOKS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonneville

City of St. Maries

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

File No. 13407

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. W. D. Wolf.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. Sept. (Month) 16 (Day) 1880 (Year)

7. AGE: 35 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: James T. Miller

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Bianca Buer

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Wolf.

(Address) St. Maries Idaho.

15. Filed Jan. 12 1916 N. L. Mulcahy Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1916, to Jan 11 1916, that I last saw her alive on Jan 11 1916, and that death occured on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Pluro-Pneumonia, Heart failure from the above disease

(Duration) — Yrs. — mos. 3 ds.

Contributory (Secondary) General debility run down Condition, & a Miscarriage

(Duration) ..... yrs. ..... mos. 3 weeks ds.

(Signed) J. J. Kinsbruner M. D.

Jan. 12 1916 (Address) St. Maries Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. Maries Idaho. DATE OF BURIAL: Jan. 14 1916

20. UNDERTAKER: N. L. Mulcahy. ADDRESS: St. Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Benewah

City of St Maries

Registration District No. 32

Primary Registration District No. 2049

(No. ..... St.)

File No. 13408

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Mary E. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 12 (Day) 87[illegible] (Year)

7. AGE: 68 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Pa

10. NAME OF FATHER Casimer Loup

11. BIRTHPLACE OF FATHER (State or Country) Pa

12. MAIDEN NAME OF MOTHER G. Stiehr

13. BIRTHPLACE OF MOTHER (State or Country) Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. W. Smith

(Address) St Maries, Idaho

15. Filed Jan 19 1916 H. F. Mukelby Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 1915, to Jan 19 1916, that I last saw h[illegible] alive on Jan 18 1916, and that death occured on the date stated above, at 1350 M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Owen D Platt M. D.

1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries Idaho | DATE OF BURIAL: Jan 21 1916

20. UNDERTAKER: H. F. Mukelby | ADDRESS: St Maries

AVIS WORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bryenvah
City of near Fernwood

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 13409
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray McNeirn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE about 35 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer on Steam
(b) General nature of industry, business, or establishment in which employed (or employer)..... Shidder in logging Camp

9. BIRTHPLACE (State or Country) Prince Edward Island N.S.

10. NAME OF FATHER Horst Knox

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER ..... ,

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Stevens.

(Address) Fernwood, Idaho.

15. Filed Jan. 26 1916 W. L. Mulcahy. Local Registrar

SVINE & FORK CO., PTRS. & BOBS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 24 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidently Killed by being struck by Car in Logging Camp

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Stevens Coroner M. D.

1-26 1916 (Address) St. Maries, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries Idaho | DATE OF BURIAL: Jan 29 1916

20. UNDERTAKER: W. L. Mulcahy | ADDRESS: St Maries.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32

Primary Registration District No. 2049

File No. 13410

Registered No. .....

1. PLACE OF DEATH.

County of Benewah

City of St. Maries (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred Hoffman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 58 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. B. Cromwell

(Address) St. Maries Idaho

Jan 28 1916

15. Filed Jan 28 1916 W. L. Mulcahy Local Registrar

STAR - GORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1916, to Jan 27 1916, that I last saw him alive on Jan 27 1916, and that death occured on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ..... Yrs. = mos. 5 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Cromwell M. D.

(Address) St. Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Jan. 29 1916

20. UNDERTAKER: W. L. Mulcahy — ADDRESS: St Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 13412
Registered No. .....

1. PLACE OF DEATH.
County of Benewah
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mike Hragovitch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Austrian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 24 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber Jack
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. L. Mulcahy
(Address) .....

15. Filed Jan 10 1916 H. L. Mulcahy Local Registrar

YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan. (Month) 9 (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916, to Jan 9 1916, that I last saw h... alive on ..... 1916, and that death occured on the date stated above, at 5-45 M.

The CAUSE OF DEATH* was as follows:
Meningitis
.....
.....
.....
(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. Lorenwall M. D.
1-10 1916 (Address) St. Maries, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries Idaho — DATE OF BURIAL: Jan 11 1916

20. UNDERTAKER: H. L. Mulcahy — ADDRESS: St Maries

FORM V. S. No. [redacted] 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Benewah

City of St Maries

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13413

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Harpin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 31 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rhode Island

10. NAME OF FATHER: Alfred Harpin

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D F Cornwall

(Address) St Maries

Jan 8 1916 N. F. Mulcahy. Local Registrar

PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21 1915, to Jan 7 1916, that I last saw h Wife alive on Jan 7 1916, and that death occured on the date stated above, at 1 to P M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of bladder & Kidneys

..... (Duration) ..... Yrs. 20 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

1/8 1916 (Signed) D F Cornwall M. D.

(Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Jan 8 1916

20. UNDERTAKER: N F Mulcahy — ADDRESS: St Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Benewah

City of N. Manos.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13414

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Johnson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Finlander	single

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1 (Year)

7. AGE above 38 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Lumber Jack

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Hon. Y Mo

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N. L. Mulcahy

(Address) N. Manos Idaho

15.

Filed Jan 12 1916 N. L. Mulcahy Local Registrar

SYMS-YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1916, to Jan 12 1916, that I last saw him alive on Jan 12 1916, and that death occured on the date stated above, at 6 a M.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar

..... (Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Owen D. Platt M. D.

Jan 12 1916 (Address) N. Manos Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL N. Manos — DATE OF BURIAL Jan 15 1916

20. UNDERTAKER N. L. Mulcahy — ADDRESS N. Manos

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 13415
Registered No. 11

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. 2615 Main st. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maxine Andreasen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 12 (Day) 15 (Year)

7. AGE: Yrs. 1 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Moscow.

10. NAME OF FATHER: Hammil

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Sophie Andreasen

13. BIRTHPLACE OF MOTHER (State or Country): Moscow.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) B R Chase
(Address) Lewiston

15. Filed 2-10-1916 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
1 (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw her alive on Jan 24th 1916,
and that death occured on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Uraemia

(Duration) Yrs. 2 mos. — ds.
Contributory (Secondary)
(Duration ..... yrs. 2 mos. 0 ds.
(Signed) E. D. Todd M. D.
19.. (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL 191...

20. UNDERTAKER: L. L. Carson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Wynn - York Co., Print. & Mfrs. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 13416
Registered No. 14

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary L Eby (died)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 11 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Lewiston Idaho

10. NAME OF FATHER Jesse Eby

11. BIRTHPLACE OF FATHER (State or Country) Wash

12. MAIDEN NAME OF MOTHER Grace M Stephenson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jesse Eby
(Address) Lewiston Idaho

15. Filed 2-10-1916 L. J. Perkins Local Registrar

SVMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 31st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11th 1916, to Jan 31st 1916, that I last saw her alive on Jan 31 1916, and that death occured on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary) none

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A M Travis M. D.

19 .... (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 2/1 1916

20. UNDERTAKER: Wasson — ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 13417
Registered No. 12

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. St. Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Justus G King

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Not known (Month) (Day) 1 (Year)

7. AGE: 42 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: L. W. King

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: W J Chapman

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A E King
(Address) Culdesac Ida

15. Filed 2-10-1916 L J Perkins Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/12/1916, to 1/26/1916, that I last saw him alive on 1/26/1916, and that death occured on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. 1 mos. 12 ds.

Contributory (Secondary) Heart failure

(Duration) Yrs. mos. ds.

(Signed) H. H. Hamm M. D.

1/26 1916 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Culdesac — DATE OF BURIAL: 1916

20. UNDERTAKER: C J Vassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 13417

Name Justin C. King

Date of Death January 26th. 1916

Cause of Death Lobar Pneumonia

Contributary Cause of death

(Sign here) F. P. Harris, M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

(No. ..., New 16th St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13418

Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ivy Ryce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennie Peeler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 3 (Day) 1872 (Year)

7. AGE: 33 Yrs. 8 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Dak

10. NAME OF FATHER: Andrew Bergani

11. BIRTHPLACE OF FATHER (State or Country): N Y

12. MAIDEN NAME OF MOTHER: Julian Post

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Bergani

(Address)

15. Filed 2-10-1916 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw her alive on Jan 30 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

Scirrhus Cancer of breast

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary) Chronic Nephritis

(Duration) 1 yrs. — mos. — ds.

(Signed) L. J. Perkins M. D.

1/30 1916 (Address) L J Perkins Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos...days. In the State ...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston

DATE OF BURIAL ..... 191...

20. UNDERTAKER: C J Vassar

ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & ENGS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 96
County of Nez Perce Primary Registration District No. 1009
City of Lewiston (No. 2nd Street Ext.)
File No. 13419
Registered No. 1
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Clarence M. Johnson
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Not known (Month) (Day) 1873 (Year)

7. AGE: 42 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. F. Harris
(Address) Lewiston, Idaho

15. Filed 2-10- 1916 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 2nd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7th 1915, to Jan 2nd 1916, that I last saw him alive on Jan 2nd 1916, and that death occurred on the date stated above, at 11:45 M.
The CAUSE OF DEATH* was as follows: Pneumonia
Hemorrhage of bowels.
Following fall from wagon
(Duration) yrs. mos. 26 ds.
Contributory (Secondary) Fall from wagon
(Duration) yrs. mos. ds.
(Signed) E. F. Harris M. D.
1/3/1916 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida. DATE OF BURIAL: 1/20 1916

20. UNDERTAKER: L. L. Vassar ADDRESS: Lewiston

Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRD-YORK CO., PRINTERS & ENGRS., DENVER 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce — Registration District No. 95
City of Lapwai — Primary Registration District No. 1009
(No. ..... St.)
File No. 13420
Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hettie Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Dec 5 (Month) (Day) 1855 (Year)

7. AGE: 60 Yrs. 1 Mos. — ds. 3
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farming
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Sheard E Moore

11. BIRTHPLACE OF FATHER (State or Country): Rochester N. Y.

12. MAIDEN NAME OF MOTHER: Eliza Buck

13. BIRTHPLACE OF MOTHER (State or Country): N. York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Effie M. Foster
(Address):

15. Filed 2-10- 1916 — L. J. Perkins, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 8th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8th 1916, to June 8th 1916, that I last saw h[illegible] alive on June 8th 1916, and that death occured on the date stated above, at 9 18 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Duration) — Yrs. — mos. 5 ds.
Contributory (Secondary): La Grippe
(Duration) — yrs. — mos. 14 ds.

(Signed) O. G. Pearson M. D.
1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lapwai — DATE OF BURIAL: 1/16 191[illegible]

20. UNDERTAKER: L J Parkins — ADDRESS: Lapwai

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 95
Primary Registration District No. 1009
(No. .... St.)

File No. 13421
Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information. Waha

2. FULL NAME Lowe Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Feb (Month) 16 (Day) 1863 (Year)

7. AGE: 52 Yrs. 10 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Jas. Lowe

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: K Alderson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. C. Wallace
(Address) Waha

15. Filed 2-10- 1916
L J Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 10th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9th 1916, to Jan 10th 1916, that I last saw h er alive on Jan 9th 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Shock Mreamic Coma
(Duration) ..... Yrs. ..... mos. 12 hrs. ds.
Contributory (Secondary) Accidental Burns
(Duration ..... yrs. ..... mos. 28 hrs. ds.
(Signed) O. C. Garrison M. D.
1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL 191

20. UNDERTAKER: L Vassa
ADDRESS Lewiston

SYMS - YORK CO., PTGS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 13422
Registered No. 4

1. PLACE OF DEATH
County of Nez Perce
City of Lapwai (No. 404 - 4th Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet Bartlett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. April (Month) 27 (Day) 1895 (Year)
7. AGE: 20 Yrs. 8 Mos. 13 ds. IF LESS than 1 day how many.....hrs. or .....min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Scholar
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Nebraska.
10. NAME OF FATHER: P. Bartlett
11. BIRTHPLACE OF FATHER (State or Country): Wis.
12. MAIDEN NAME OF MOTHER: Myrtle L. O'Neill
13. BIRTHPLACE OF MOTHER (State or Country): Ind.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fred B. Bartlett
(Address) Lewiston Ida
15. Filed 2-10- 1916 L. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 10 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from February 17 1916, to Jan. 10 1916, that I last saw h.. alive on Jan. 10 1916, and that death occured on the date stated above, at 2:15 P. M.
The CAUSE OF DEATH* was as follows:
Hyperpituitarism
(Duration) 6 Yrs. mos. ds.
Contributory (Secondary) Consumption
(Duration 1/2 yrs. mos. 1 hrs. ds.
(Signed) Elmer E. Broadbeck M. D.
Jan 10 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: 1/10 1916
20. UNDERTAKER: J. Lanon — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

RYDER - YORK CO., PTRS. & ENGS. 24659

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13423

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1009

(No. 1025 Idaho St.)

2. FULL NAME Infant of Ida Mark Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 10 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 1 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Lewiston

10. NAME OF FATHER Mark Smith

11. BIRTHPLACE OF FATHER (State or Country) Mont

12. MAIDEN NAME OF MOTHER Ida Taylor

13. BIRTHPLACE OF MOTHER (State or Country) Kan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mark Smith

(Address) Lewiston Ida

15. Filed 2-10- 1916 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1916, to Jan 10 1916, that I last saw her alive on Jan 10 1916, and that death occured on the date stated above, at 5 30 A M.

The CAUSE OF DEATH* was as follows:

Premature birth. 6½ mo.

1 day.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Same

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Edgar L Wurke M. D.

1-11 1916 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Jan 11 1916

20. UNDERTAKER: C. J. Vassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

[redacted] of Idaho
DEPARTMENT OF HEALTH
Vital Statistics

File 13424

Registered No. 6

Registration District No. 96

Primary Registration District No. 1009

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston (No. Good Samaritan Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis Kone

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE [illegible] Yrs. ..... Mos. ..... ds. approximately.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Gardener

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): Prussia Germany

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Prussia Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leo E Ent

(Address) Lewiston Idaho

15. Filed 2-10- 1916 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1915, to Jan 13 1916, that I last saw h[illegible] alive on Jan 12 1916, and that death occured on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Edmund A Bean M. D.

Jan 13 1916 (Address) Lewiston Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 2 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Grangeville

Former or usual residence Grangeville

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 1/15 1916

20. UNDERTAKER: L. J. Vassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 96

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13425

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

Registration District No.

Primary Registration District No. 1009

(No. 1701 G-ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace M. Stevenson Eby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 4 (Day) 1883 (Year)

7. AGE: 32 Yrs. 3 Mos. 9 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Waha Idaho

10. NAME OF FATHER: William Stevenson

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse Eby

(Address) Waha Idaho

15. Filed 2-10-1916 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10th 1916, to Jan 15th 1916, that I last saw h alive on Jan 14th 1916, and that death occured on the date stated above, at 5 9 M.

The CAUSE OF DEATH* was as follows: Exptalumic Goiter (myxtem)

(Duration) Yrs. 6 mos. 5 ds.

Contributory (Secondary): La Grippe - Chedhood

(Duration yrs. mos. 7 ds.

(Signed) J W Francis M. D.

1916 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 191

20. UNDERTAKER: Lewis — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMB - YORK CO., PTRS. & SOBS. 24858

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
Registration District No. 9c
Primary Registration District No. 1009
(No. ..... St.)
File No. 13426
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Copshall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 24 (Day) 1 73 (Year)

7. AGE: 73 Yrs. ~~94~~ Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Butcher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Copshall

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Aunt Runn

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elvira Copshall
(Address) Lewiston Ida

15. Filed Jan 15 1916 2102 1916
L D Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/11/1915, to 1/15/1916, that I last saw h[illegible] alive on 1/14 1916, and that death occured on the date stated above, at 11:30 P.M.
The CAUSE OF DEATH* was as follows:
Senility
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) 2 yrs. 1 mos. ..... ds.
(Signed) J J Hamm M. D.
1/15 1916 (Address) Pierce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: Jan 17 1916
20. UNDERTAKER: Brown Undertaking Co — ADDRESS: Lewiston

BYRNE - YORK CO., PTGS. & STNRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13427
Registered No. 9

1. PLACE OF DEATH. X
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. 1827, Seventh Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kelbert E. Taylor

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Dec (Month) 18th (Day) 1851 (Year)

7. AGE: 64 yrs. mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Iron worker
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Joseph Taylor

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Loretta Filgraham

13. BIRTHPLACE OF MOTHER (State or Country): ~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed 2-10-1917 L. J. Peterson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 16th (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1914, to Jan 16th 1917
that I last saw h[im] alive on Jan 15th 1917
and that death occurred on the date stated above, at 12 20 AM.

The CAUSE OF DEATH* was as follows:

Cancer of Liver & Gall Bladder

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. Carson M. D.
19 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 3 yrs mos ds. In the State yrs mos ds.
Where was disease contracted, if not at place of death? Lewiston Ida
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glenhaven Wis
DATE OF BURIAL: 1/11 1917

20. UNDERTAKER: Brown Undertaking Co
ADDRESS: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 13428
Registered No. 10

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston (No. 128 18th Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Fertsberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Jan (Month) 1st (Day) 1 (Year)

7. AGE: 88 Yrs. ... Mos. 16 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Joseph Knapp

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Davis

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Agnes Shafer
(Address)

15. Filed 2-10- 191 6 L-J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1916, to Jan 16 1916, that I last saw h[er] alive on Jan 16th 1916, and that death occured on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonea

(Duration) ... Yrs. ... mos. 3 ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) D C Pearson M. D.
19 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL ... 191...

20. UNDERTAKER: D C Pearson — ADDRESS: Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRD - YORK CO., PTRS. & BKBS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13431

Registered No. 2

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 7168
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ann Groves

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH
October 8 1845
(Month) (Day) (Year)

7. AGE
70 yrs. 3 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Thomas Whipple

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER Sarah Ann Smith

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) E W Groves - Kingston Ida

15.
Filed Jany 23 1916 J. M. Fairley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January 22 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 13 1916, to Jany 22 1916
that I last saw her alive on Jany 22 1916,
and that death occurred on the date stated above, at 1035 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. V. ds.
Contributory (Secondary) La Grippe
(Duration) ..... yrs. ..... mos. 10 ds.
(Signed) J. M. Fairley M. D.
1/22 1916 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: Jany 25 1916

20. UNDERTAKER: W. E. Stoddard
ADDRESS: Wallace, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

4-16 - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13432

Registered No. 3

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Clearwater
City of Orofino (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 7168

2. FULL NAME George N Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: May (Month) 24 (Day) 1839 (Year)

7. AGE: 76 yrs. 10 mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Wilson

11. BIRTHPLACE OF FATHER (State or Country): Ohio Va

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George W. Wilson
(Address) Ahsahka Ida

15. Filed Jany 25 1916 J. M. Tinsley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1915, to January 23 1916, that I last saw him alive on Dec 20 1915, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Cancer of Throat
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) J. M. Tinsley M. D.
1/25 1916 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino, Ida
DATE OF BURIAL: January 25 1916

20. UNDERTAKER: W. E. Stoddard
ADDRESS: Kiffel, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

EVANS-NEW YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 13433
Registered No. 4
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James J. Clark.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1871 (Year)

7. AGE: 45 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Accountant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Johnnie Givens
(Address) Orofino. Idaho.

15. Filed July 1 1916 J. M. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 26. (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26. 1914., to Jan 26. 1916., that I last saw h[illegible] alive on Jan 26. 16, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Paresis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Johnnie Givens M. D.
Jan 26 1916. (Address) Orofino. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 8 mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? ?
Former or usual residence Idaho.

19. PLACE OF BURIAL OR REMOVAL: N. I. Dan. Cemetery.
DATE OF BURIAL: Jan. 29. 1916.

20. UNDERTAKER: A. B. Carlton
ADDRESS: Orofino, Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 90

Primary Registration District No. 2168

File No. 13436

County of Clearwater

City of Orofino (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lorenza Dow Snyder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1864 (Year)

7. AGE: 51 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Sampson Snyder

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Bonner

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lawson Snyder
(Address) Orofino Idaho

15. Filed Feby 1 1916 J. McNally Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1916 to Oct 1916
that I last saw him alive on Jan 12 1916
and that death occurred on the date stated above, at 12:15 M.

The CAUSE OF DEATH* was as follows:
Cancer of Liver & Fibroid of Pancreas

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle Hommel M. D.

1/13 1916 (Address) Orofino

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Orofino Ida	1/14 1916
20. UNDERTAKER	**ADDRESS**
W. E. Stoddard	Gifford

If death occurred from violence, state CAUSE OF DEATH in plain terms, so that it may be judged whether it was accidental, suicidal or homicidal. See instructions on back of certificate. Statement of OCCUPATION is very important.

SYMS - YORK CO., PTRS. & BDRS. 15760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 13437
Registered No. 8

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julia Dobson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Feb (Month) 21 (Day) 1857 (Year)

7. AGE: 59 yrs. 10 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Maker
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Dobson

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Julia Dobson

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julian Dobson
(Address) Gellen Ida

15. Filed Jany 17 1916 J. M. Hanley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 4 1916, to Jany 15 1916, that I last saw h[illegible] alive on Jany 13 1916, and that death occurred on the date stated above, at —— M.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(Duration) ... yrs. ... mos. 11 ds.

Contributory (Secondary) Lagrippe

(Duration) ... yrs. ... mos. 20 ds.

(Signed) J. M. Hanley M. D.

1/16 1916 (Address) Orofino

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gilbert Ida — DATE OF BURIAL: Jan 17 1917

20. UNDERTAKER: H. E. Stoddard — ADDRESS: Clifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Owyhee.

City of Castle Creek.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 43.

Primary Registration District No. 2120.

(No. ....., ... St.)

File No. 13439

Registered No. 28

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Mary Lindberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed.

6. DATE OF BIRTH: October 24th 1838
(Month) (Day) (Year)

7. AGE: 77 yrs. 2 mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nursing
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway.

10. NAME OF FATHER: Peterson

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minnie Davey

(Address) Castle Creek.

15.

Filed January 8, 1916 W. H. Lethaylen, M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January 5th 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Said to have been due to general weakness & anaemia, superinduced by old age, & a hard life.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Silver City Cemetary

DATE OF BURIAL: Jan 8th 1916.

20. UNDERTAKER: John Greete

ADDRESS: Silver City Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & RDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13440
Registered No. 29

1. PLACE OF DEATH.
County of Cuyhee
City of Reynolds,
(No. ..... St.)
Registration District No. 43
Primary Registration District No. 2120
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. Christopher Johnston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb 19 1830 (Month) (Day) (Year)

7. AGE: 85 Yrs. 10 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Stockman

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Benj Johnston Jr.

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Katherine Byrd

13. BIRTHPLACE OF MOTHER (State or Country) S. Caroldina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Family Record
(Address) Rey-fraldy Ida

15. Filed Jan 17 1916. H. H. Schuyler M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 10 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1913, to Jan 1 1916, that I last saw him alive on Jan 1 1916, and that death occured on the date stated above, at ..... P.M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart disease

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H P Ross M. D.
1/19 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Reynolds Creek cemetary
DATE OF BURIAL: Jan 17 1916

20. UNDERTAKER: None
ADDRESS: —

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 17

Primary Registration District No. 2057

File No. 13441

Registered No. 4788

County of .....

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Haugen McCall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: April (Month) 8 (Day) 1833 (Year)

7. AGE: 80 yrs. ..... mos. 8 ds. 27

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N Y

10. NAME OF FATHER: — McCall

11. BIRTHPLACE OF FATHER (State or Country): N. Y

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): N Y

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jennette M. McCall
(Address) Athol

15. Filed 2/10 1916 D D Downes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 5th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 1. 1916, to Jany 5. 1916, that I last saw him alive on Jany 1. 1916 and that death occurred on the date stated above, at 12 00 M. noon

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(Duration) several yrs. mos. ..... ds.

Contributory (Secondary) Old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Wing M. D.

1/6 1916 (Address) Rathdrum, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Ida — DATE OF BURIAL: Jan 7 1916

20. UNDERTAKER: O. W. Stone — ADDRESS: Rathdrum

SYMS - YORK CO., PTRS. & BDRS. 19760

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. Information should be carefully supplied.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13443
Registered No. 490

1. PLACE OF DEATH
County of [redacted] Kootenai
City of Mc Guires
Registration District No. 1st
Primary Registration District No. 2051
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Ernest Metz

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH: Aug. (Month) 19 (Day) 1823 (Year)
7. AGE: 92 yrs. 4 mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Coberg on the Rhine Germany
10. NAME OF FATHER: Dont know
11. BIRTHPLACE OF FATHER (State or Country): Dont know.
12. MAIDEN NAME OF MOTHER: Dont know
13. BIRTHPLACE OF MOTHER (State or Country): Dont know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [redacted] Henry A Metz
(Address) Mc. Guires, Idaho.
15. Filed 3/10 1916 J. J. Sheeran Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: [redacted] Jan. (Month) 11th (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 8th 1916, to Jan 11th 1916
that I last saw h[redacted]m alive on Jan. 11th 10 a.m. 1916,
and that death occurred on the date stated above, at 7:30 P. M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia Acute
..... (Duration) ..... yrs. ..... mos. 7 ds.
Contributory (Secondary) Senile [redacted]
and Valvular heart disease Degeneration
..... (Duration) ..... yrs. — mos. [redacted] ds.
(Signed) B F Campbell M. D.
Jan. 12th 1916 (Address) Post Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant View — DATE OF BURIAL: 1—14 1916
20. UNDERTAKER: Turnbull Co — ADDRESS: Spokane

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13444

Registered No. 489

1. PLACE OF DEATH.

County of Kootenay

City of Post Falls

Registration District No. 12

Primary Registration District No. 2017

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alvira Chase

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 27 (Day) 1839 (Year)

7. AGE: 76 Yrs. 5 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Joseph S. Chase

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Betsey Finney

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mayor Chase

(Address) Post Falls Idaho

15. Filed 1/10 1916 D. S. Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1915, to Jan 1 1916, that I last saw her alive on Jan 1 1916, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma Ventricle cancel
Kidneys Complications Uremia
Sclerosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) B E McCoy M. D.

1-9-1916 (Address) Spokane Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Trask — DATE OF BURIAL: 1-10 1916

20. UNDERTAKER: J B Hagen — ADDRESS: Spokane Trask

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2051
File No. 13445
Registered No. 1091

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mabel F. Papendick

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept. (Month) 20 (Day) 1841 (Year)

7. AGE: 57 yrs. 4 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Moses H. Smith

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Elsie Gale

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elsie G. Papendick
(Address) Rathdrum, Ida.

15. Filed 2/10 1916 O W Brewer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January 20th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ for over 3 yrs, to ..... 191..., that I last saw her alive on Jany 20. 1916 and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(Duration) over 3 yrs. mos. ds.
Contributory Chronic Bronchitis (Secondary)
(Duration) over 3 yrs. mos. ds.

(Signed) Frank Ware M. D.
1/22 1916 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Ida — DATE OF BURIAL: Jan 23 1916
20. UNDERTAKER: O. W. Stone. — ADDRESS: Rathdrum

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13446

Registered No. 492

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 17

Primary Registration District No. 205-1

County of Kootenai

City of E. Emmett (No. ..., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pearl Infant Gorham

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: Jan 27 (Month) / 27 (Day) 1916 (Year)

7. AGE: ... yrs. ... mos. 4 ds. IF LESS than 1 day how many ... hrs. or ... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): E. Emmett

10. NAME OF FATHER: Gaythen Gorham

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Greer

13. BIRTHPLACE OF MOTHER (State or Country): N. C

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Gaythen Gorham
(Address): Van Fall, R 7 D

15. Filed 2/10 1916 — S. D. Freeman, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1916., to Jan 31 1916., that I last saw h... alive on Jan 27 191..., and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Puerperal Obstruction from Convulsions

(Duration) ... yrs. ... mos. 4 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) S. D. Freeman M. D.

19... (Address) ...

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Pleasant View — DATE OF BURIAL: Feb 1 1916

20. UNDERTAKER: Jones — ADDRESS: E

SYMS - YORK CO., PTRS. & SONS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 17

Primary Registration District No. 2087

File No. 13448

County of Kootenai

City of Rathdrum (No. ....., ... St.)

Registered No. 495

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Franklin Humphrey

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH: November 16 1915
(Month) (Day) (Year)

7. AGE — 1 mo. 21 ds. — yrs. 7 wks. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rathdrum, Ida.

10. NAME OF FATHER: George F. Humphrey

11. BIRTHPLACE OF FATHER (State or Country): Washgtn.

12. MAIDEN NAME OF MOTHER: Cora Gaston

13. BIRTHPLACE OF MOTHER (State or Country): N. Dak.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George F. Humphrey
(Address) Rathdrum Idaho

15. Filed 2/10 1916 D S Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January 6th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 6 1916, to Jany 6 1916, that I last saw h— alive on Jany 6 1916 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Clonic Convulsions

(Duration) — yrs. — mos. 2 hrs

Contributory (Secondary) Acute Indigestion

(Duration) — yrs. — mos. 2 hrs ds.

(Signed) Frank Wm. M. D.

1/7 1916 (Address) Rathdrum Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191..

20. UNDERTAKER S Burke | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13449

Registered No. 1

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 1010

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Luella E. Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. 37.

Jan (Month) 30 (Day) 1889 (Year)

7. AGE 26 Yrs. 11 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Neb

10. NAME OF FATHER P. O. Dutcher

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Clara Lynds

13. BIRTHPLACE OF MOTHER (State or Country) N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oscar D Carter

(Address) Huntington Ore

15.

Filed 1-14 1916 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-9 1916, to 1-12 1916, that I last saw her alive on 1-12 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) about 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

1/13 1916. (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Caldwell Ida

DATE OF BURIAL: .....191.....

20. UNDERTAKER: Northam & McCann

ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13450

Registered No. 2

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 1010

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Teresa Howard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 1 (Day) 1901 (Year)

7. AGE: 14 Yrs. 4 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John W Howard

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Sarah E Hays

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert H. Howard

(Address) Weiser Ida

15. Filed January 16th 1916 — W. R. Hamilton, Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 16th 1916. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 1st 1915, to January 16th 191..., that I last saw her alive on January 6th 191..., and that death occured on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 2 Yrs. ... mos. ... ds.

Contributory (Secondary) Acute Articular Rheumatism

(Duration ... yrs. ... mos. ... ds.

(Signed) W. R. Hamilton M. D.

1/17 1916. (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Creek Cem — DATE OF BURIAL: Jan 18 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13451
Registered No. 3

1. PLACE OF DEATH.
County of Washington
City of Weiser
(No. ....., ... St.)
Registration District No. 86
Primary Registration District No. 1010
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily L. Kilpatrick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 30 (Day) 1 (Year)

7. AGE 38 Yrs. 6 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: John A. Fiero

11. BIRTHPLACE OF FATHER (State or Country): ——

12. MAIDEN NAME OF MOTHER: Mary Hunt

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John A. Kilpatrick
(Address) Weiser Idaho

15. Filed January 15th 1916 — W. R. Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1916, to Jan 18 1916, that I last saw her alive on Jan 18 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Obstructed bowel

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
Jan 19 16 (Address) W. M. Mitchell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pen Yan N.Y. — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: L. C. Northcutt — ADDRESS: Weiser Ida

BYRD - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 1010

(No. ..... , ... St.)

File No. 13452

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fredsrika Hinze

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. February (Month) 23 (Day) 1848 (Year)

7. AGE: 67 Yrs. 11 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wernigerode Germany

10. NAME OF FATHER Earnest Mehle

11. BIRTHPLACE OF FATHER (State or Country) Elbingenrode Germany

12. MAIDEN NAME OF MOTHER Frederika

13. BIRTHPLACE OF MOTHER (State or Country) Elbingenrode Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Hinze

(Address) Weiser Idaho

15. Filed Jan 26 1916

M. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916, to Jan 25 1916, that I last saw h[illegible] alive on Jan 25 1916, and that death occured on the date stated above, at 2-30 M.

The CAUSE OF DEATH* was as follows:

Senile Gangrene

(Duration) ..... Yrs. ..... mos. 60 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. R. Hamilton M. D.

1/26/1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: Jan 28 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13453

Registered No. ____

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 101C.

(No. ____ ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lillian Deane

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 9 (Day) 1872 (Year)

7. AGE: 43 Yrs. 4 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Michigan

10. NAME OF FATHER Isaac S. Deane

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Almira Boulton

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs G.W. Garrett

(Address) Weiser Idaho

15. Filed Jan 31st 1916 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 31st, 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1915, to Jan. 30th 1916, that I last saw her alive on Jan 29th 191, and that death occured on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) .....

(Duration yrs. mos. ds.

(Signed) W. R. Hamilton M. D.

1/31/1916 (Address) Weiser, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kalamazoo, Mich — DATE OF BURIAL: ____ 191

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE-YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4457

Registered No. 13

1. PLACE OF DEATH.

County of Shoshone

City of Wardner

(No. ..... St.)

Registration District No. 123

Primary Registration District No. 2201

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred A Hogen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	White	Married

6. DATE OF BIRTH.

Dec (Month) 22 (Day) 1867 (Year)

7. AGE

48 Yrs. 0 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... miner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Norway

10. NAME OF FATHER Anderson Hogan

11. BIRTHPLACE OF FATHER

(State or Country) Norway

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER

(State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C A Rosenhalg

(Address) Wardner Idaho

15.

Filed 1/15 1916 Geo D Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h...alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) No Doctor Present, ... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Kellogg Idaho

DATE OF BURIAL Jan 16 1916

20. UNDERTAKER M. C. Thomlinson

ADDRESS Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 123

Primary Registration District No. 2201

File No. S 13458

County of Shoshone

City of Enaville (No. 6, St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eric Huarinmaa

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH

..... (Month) ..... (Day) 1837 (Year)

7. AGE

79 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Finland

10. NAME OF FATHER Huarinmaa

11. BIRTHPLACE OF FATHER (State or Country) Finland

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Jewett

(Address) Enaville, Idaho

15.

Filed 2/10 191 6 Geo S Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Old age - no doctor.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kingston Idaho.	Jan 18 1916.
20. UNDERTAKER	ADDRESS
M C Blanchett	Kellogg Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2201
Primary Registration District No. 2201
File No. 43459
Registered No.

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah E. Yard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
F.	W.	married

6. DATE OF BIRTH
Dec (Month) 10 (Day) 1851 (Year)

7. AGE
64 yrs. 4 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Tennessee near Jackson

10. NAME OF FATHER Mr. English

11. BIRTHPLACE OF FATHER
(State or Country) S. Carolina

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER
(State or Country) S. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Yard
(Address) Kellogg Ida

15.
Filed 2/10 1916 Geo S Lesher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb. (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1916 to Feb 6 1916 that I last saw her alive on Feb 6 1916 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo S Lesher M. D.
2/10 1916 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kellogg, Idaho.	Feb 6 1916

20. UNDERTAKER	ADDRESS
M. C. Shanklin.	Kellogg.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 27
County of Franklin Primary Registration District No. 2119
City of Mink Creek (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 13460
Registered No. 3
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carma Christensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH: Feb. (Month) 18 (Day) 1915 (Year)

7. AGE: yrs. 11 mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mink Creek

10. NAME OF FATHER Stephen C Christensen

11. BIRTHPLACE OF FATHER (State or Country) Logan Utah.

12. MAIDEN NAME OF MOTHER Emma Jensen

13. BIRTHPLACE OF MOTHER (State or Country) Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marten Christensen
(Address) Mink Creek Idaho

15. Filed 2-15 1916 Dr A R Rutter Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 7th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1916, to Jan 7 1916
that I last saw her alive on Jan 7 1916,
and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. F. Parkinson M. D.
19... (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Mink Creek — DATE OF BURIAL: Jan 9 1916

20. UNDERTAKER: None — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13461

Registered No. 4

1. PLACE OF DEATH.

County of Franklin

City of Preston

(No. ....., ... St.)

Registration District No. 27

Primary Registration District No. 2119

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katie Ingeham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 11 (Day) 1914 (Year)

7. AGE ..... Yrs. 16 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Preston, Franklin Co Ida

10. NAME OF FATHER Elmer Ingeham

11. BIRTHPLACE OF FATHER (State or Country) Rivendal Ida

12. MAIDEN NAME OF MOTHER Maud Martin

13. BIRTHPLACE OF MOTHER (State or Country) Preston Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmer Ingeham

(Address) Preston

15.

Filed 2-10 1916

D. A. Ruetter
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1st (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 2d 1916, to January 10 1916, that I last saw her alive on January 10 1916, and that death occured on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows: Pneumonia — Bronchs

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) —

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S A Caufield M. D.

1/11 1916 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston Ida — DATE OF BURIAL: 1/12 1916

20. UNDERTAKER: H. A. Skidmore — ADDRESS: Preston

Per. A. A. Monson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13462

Registered No. 2

1. PLACE OF DEATH.

County of Franklin

City of Whitney

(No. ....., ... St.)

Registration District No. 27

Primary Registration District No. 2119

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Orr Hull

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Oct (Month) 10 (Day) 1869 (Year)

7. AGE 46 Yrs. 3 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Franklin, Idaho

10. NAME OF FATHER Robert Hull

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Mary Ann Chadwick

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. O. Hull

(Address) .....

15. Filed Jan 10 1916

D. A. Reese Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1916, to Jan 19 1916, that I last saw him alive on Jan 18 1916, and that death occured on the date stated above, at 4-15 P.M.

The CAUSE OF DEATH* was as follows:

(a) Chronic Endocarditis

.....

.....

.....(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Mitral Insufficiency

.....(Duration 15 yrs. ..... mos. ..... ds.

(Signed) G. G. Parkinson M. D.

19..... (Address) Preston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Whitney Ida — DATE OF BURIAL: 1/23 1916

20. UNDERTAKER: A. A. Skidmore — ADDRESS: Preston

per A. A. Swanson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMB - (SMK CO., PTRS. & SDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13463

Registered No. 5

1. PLACE OF DEATH.

County of Franklin

City of Preston

(No. ....., ... St.)

Registration District No. 27

Primary Registration District No. 2119

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Jane Read

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Married~~ widowed

6. DATE OF BIRTH. Jan (Month) 21 (Day) 1916 (Year)

7. AGE: 84 Yrs. 4 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Tennessee

10. NAME OF FATHER Jas McClellan

11. BIRTHPLACE OF FATHER (State or Country) U. S. A.

12. MAIDEN NAME OF MOTHER Cynthia Stewart

13. BIRTHPLACE OF MOTHER (State or Country) U. S. A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Read

(Address) .....

15. Filed 2-10 1916 (Dr. A. McCulloch) Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1916, to Jan 21 1916, that I last saw her alive on Jan 21 1916, and that death occured on the date stated above, at 9:15 P. M.

The CAUSE OF DEATH* was as follows: Pneumonia - Bronchs

(Duration) ✓ Yrs. ✓ mos. 4 ds.

Contributory (Secondary) General debility

(Duration ✓ yrs. ✓ mos. ✓ ds.

(Signed) G. W. Stake M. D.

Jan 21 1916. (Address) Preston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho — DATE OF BURIAL: 1/26 1916

20. UNDERTAKER: H. A. Skidmore — ADDRESS: Preston

per A. A. Mason

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13464

Registered No. 1

1. PLACE OF DEATH.

County of Franklin

City of Riverdale

(No. ....., ... St.)

Registration District No. 27

Primary Registration District No. 2119

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elvira Packer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	White	married

6. DATE OF BIRTH.

X (Month) 10 (Day) 25 1852 (Year)

7. AGE

63 Yrs. 3 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Clinton Meehan

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Margaret Emma Chaplin

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W M Packer

(Address) Riverdale

15.

Filed 2-10 1916 D A Rencher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1916, to Jan 16 1916, that I last saw her alive on Jan 16 1916, and that death occured on the date stated above, at 10 a M.

The CAUSE OF DEATH* was as follows:

Diabetes

.....(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D A Caufield M. D.

Jan 18 1916 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Riverdale	1/21 1916

20. UNDERTAKER	ADDRESS
W. A. Sidmore Per A. A. Thorson	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2153-

File No. 13466

City of Sandpoint (No. ....., ... St.)

Registered No. 836

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Lyons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH

..... 1
(Month) (Day) (Year)

7. AGE

..... yrs. ..... mos. 1 ds. 16 hrs.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Herbert Lyons

11. BIRTHPLACE OF FATHER
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Angie Walker

13. BIRTHPLACE OF MOTHER
(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herbert Lyons

(Address) ~~Herbert Lyons~~ SR

15.

Filed Feb 9 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 31 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1916, to Jan 31 1916 that I last saw him alive on Jan 31 1916, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth abt 1-6 mo

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.

19.... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint	Jan 31 191
20. UNDERTAKER	**ADDRESS**
C M Brower	Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2135

File No. 13468

County of

City of (No. , St.)

Registered No. 846

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. O. Absolon Meillen

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: (Month) April (Day) 10 1870

7. AGE: 45 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION: Blacksmith
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: Jude Meillen

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Henriette Buisson

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Juliana Meillen
(Address) 120 Euclid Avenue

15. Filed Feb 9 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1915, to Jan 2 1916, that I last saw h[illegible] alive on Jan 2 1916, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Sarcoma of Mesentery
Was operated by Dr Mayo for
Duodenal ulcer

(Duration) yrs. mos. ds.

Contributory (Secondary) Duodenal ulcer

(Duration) yrs. mos. ds.

(Signed) Wm J Mayo M. D.

19 (Address) Rochester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida. DATE OF BURIAL: 1/5 1916

20. UNDERTAKER: E M Brown ADDRESS: S P

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 89
Primary Registration District No. 2155
File No. 13469
Registered No. 8 3 7

1. PLACE OF DEATH.
County of Bonner
City of Hope
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Margaret Dury

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)
7. AGE: 64 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Switzerland
10. NAME OF FATHER: [illegible]
11. BIRTHPLACE OF FATHER (State or Country): Switzerland
12. MAIDEN NAME OF MOTHER: [illegible]
13. BIRTHPLACE OF MOTHER (State or Country): [illegible]
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. K. Knapp
(Address) Hope
15.
Filed Feb 9 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 4th (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 4th 1916, to Jan 4 1916
that I last saw h er alive on Jan 4 1916,
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
.....
.....
..... (Duration) ..... yrs. ..... mos. 1 hour
Contributory (Secondary) Abdominal Tumor probably attached to Stomach or Liver (Duration) Liver yrs. 6 mos. ..... ds.
(Signed) W. M. Knapp M. D.
Jan 5 1916 (Address) Hope

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hope Idaho — DATE OF BURIAL: Jan 7 1916
20. UNDERTAKER: E. M. Brower — ADDRESS: Sand Point

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78 McK.

Primary Registration District No. 2185

File No. 13470

County of

City of (No. , St.)

Registered No. 848

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah J. Bowen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 64 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Andrew Parnell

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Zimmer

(Address)

15. Filed Feb 9 1916 M M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1915, to Jan 21 1916, that I last saw h[illegible] alive on Dec 28 1915, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Grip —

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Cardiac dilatation

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M M McKinnon M. D.

..... 19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint

DATE OF BURIAL: 1/6 1916

20. UNDERTAKER: E. V. Brown

ADDRESS: Sandpoint

CIANS should state CAUSE OF DEATH in plain ment of OCCUPATION is very important. See instruc[illegible] on back of certificate. Exact statement may be properly classified.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78 Jackson

Primary Registration District No. 2165

File No. 13471

County of Bonner

City of Sandpoint (No. ....., ... St.)

Registered No. 849

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nathan Hutchison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH

..... 1
(Month) (Day) (Year)

7. AGE

74 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Lumberjack

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O M Brouner

(Address) Sandpoint

15.

Filed Feb 9 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 6 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11- 1915, to Jan 6- 1916, that I last saw him alive on Jan 6- 1916, and that death occurred on the date stated above, at 11-9 M.

The CAUSE OF DEATH* was as follows:

Uremic Coma —

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) Fatty heart. dropsy — Cystitis

(Duration) 2 3 yrs. ..... mos. ..... ds.

(Signed) O M Brouner M. D.

19 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Idaho	Jan 8 1916
20. UNDERTAKER	**ADDRESS**
O M Brouner	S. P.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of

Primary Registration District No. 2153

File No. 13472

City of (No. , St.)

Registered No. 85

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Sylvester Sharp.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

(Month) (Day) 1 (Year)

7. AGE 30 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Brakeman

(b) General nature of industry business, or dstablishment in which employed (or employer) G. N.

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W R Krueger

(Address) Kellyard Mt.

15.

Filed Feb 9 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 11 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1916 to Jan [redacted] 1916, that I last saw h[redacted] alive on Jan [redacted] 1916 and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

[redacted] Following Railroad Injury

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. J. Bagley M. D.

1/11 1916 (Address) Bonners Ferr

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane Wn	1/11 1916
20. UNDERTAKER	ADDRESS
E M Brown	[illegible]

Please fill in all items, and make them as complete as possible. Important. See instructions on back of certificate. ment of OCCUPATION is very important.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2155

File No. 13473

City of Sandpoint

(No. ....., ... St.)

Registered No. 831

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George [illegible] Dickson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

40 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... miner

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E M Brown

(Address) Sandpoint Ida

15. Filed Feb 9 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 14 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1916, to Jan 14 1916, that I last saw h[illegible] alive on Jan 13 1916, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows: Cardiac Asthma

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory Bronchitis
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.

19 ..... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Ida	Jan 20 1916

20. UNDERTAKER	ADDRESS
E M Brown	Sp

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

Primary Registration District No. 2156

File No. 13474

County of Bonner

City of Sandpoint (No. ....., ... St.)

Registered No. 802

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lillie May Finney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	married

6. DATE OF BIRTH

Aug (Month) 18 (Day) 1885 (Year)

7. AGE

30 yrs. 4 mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) St Louis, Mo.

10. NAME OF FATHER Mr. John O'Neill

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Lillie Belle Thames.

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W Finney

(Address) 603 Cedar St Sandpoint Idaho

15. Filed Feb 7 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1915, to Jan 1916, that I last saw h[illegible] alive on Jan 15 1916, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M M Kinnon M. D.

19.... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Idaho	Jan 17 1916
20. UNDERTAKER	ADDRESS
E M Bonner	S. P.

CIANS should state CAUSE OF DEATH in plain [illegible], so that it may be properly classified. Exact statement of information should be [illegible]; ment of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Jackson State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78
Primary Registration District No. 215 5
File No. 13475
Registered No. 853

County of Bonner
City of Sandpoint (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Alexander

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

56 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E M Brower

(Address) Sandpoint

15.

Filed Feb 9 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 21 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9 1915, to Jan 21 1916, that I last saw him alive on Jan 20 1916, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Mouth, throat & lung cancerous infiltration

..... (Duration) ..... yrs. 9 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R W Jackson M. D.

19 ..... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Idaho	Jan 24 1916

20. UNDERTAKER	ADDRESS
E M Brower	S. P.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 913-5
File No. 13476
Registered No. 85-4

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert McMeekin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) Aug (Day) — (Year) 1

7. AGE: 31 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Brakeman
(b) General nature of industry business, or dstablishment in which employed (or employer): Logging Train

9. BIRTHPLACE (State or Country): Ottawa Canada

10. NAME OF FATHER: William McMeekin

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Hanna
(Address) Coeur d Alene Ida.

15. Filed Feb 9 1916 M. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
R.R. accident Fracture Skull.

..... (Duration) Instant yrs. mos. ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) M. M. Knapp Coroner M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Washburn Ida.
DATE OF BURIAL: 2/3 1916

20. UNDERTAKER: E M Brown
ADDRESS: Sandpoint

WRITE PLAINLY. INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information ... fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF ... in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21

County of Alkaye' Primary Registration District No. 2074

City of Hailey. (No. ....., ... St.)

File No. 13477

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cora Pederson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): sgle

6. DATE OF BIRTH. Jan. (Month) 13. (Day) 1916. (Year)

7. AGE: ..... Yrs. ..... Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Hailey, Ida.

10. NAME OF FATHER: C. Pederson.

11. BIRTHPLACE OF FATHER (State or Country): N. Dakota.

12. MAIDEN NAME OF MOTHER: Clara Kelley.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Kelley

(Address) Hailey, Ida.

15. Filed Jan 18 1916. Robert E. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 17. (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1916, to Jan 17 1916, that I last saw her alive on Jan 17 1916, and that death occured on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) asthenia

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Kennaman M. D.

1/17 1916 (Address) Hailey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hailey	Jan 17 1916
20. UNDERTAKER R. N. Harris	ADDRESS Hailey

6Y108 - YORK CO., PTRS. & SONS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 13478
Registered No. 3

1. PLACE OF DEATH.
County of Boise
City of Idaho
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME L. W Walker

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 77 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): —

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jesse H. Jacobs
(Address) Hailey Ida.

15. Filed Jan 18 1916 Robert H Wright Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1915, to Jan 17 1916, that I last saw him alive on Jan 17 1916, and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Paralysis Exposure
Few hours (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Senility, Chronic Parenchymatous nephritis
Years (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E W Kleinman M. D.
1/17 1916 (Address) Hailey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey — DATE OF BURIAL: Jan 19 1916

20. UNDERTAKER: R D Harris — ADDRESS: Hailey

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13479

Registered No. 4

Registration District No. 21

Primary Registration District No. 2022

1. PLACE OF DEATH.

County of Blaine

City of Hailey (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Hill.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH. — (Month) (Day) 1 (Year)

7. AGE: 66 abt. Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Reymond
(Address) Hailey Ida.

15.
Filed Jan 26 1916.
R. M. Hillyard
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h— alive on — 191...,
and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) Working in mines
(Duration) — yrs. — mos. — ds.

(Signed) R. M. Hillyard M. D.
Jan. 26 1916 (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida. DATE OF BURIAL: Jan 27 1916.

20. UNDERTAKER: Ralph S. Harris. ADDRESS: Hailey Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13480

Registered No. 1

1. PLACE OF DEATH.

County of Blaine.

City of near Broadford. (No. ....., ... St.)

Registration District No. 21

Primary Registration District No. 2075

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Angelo Peterlin.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 10 (Day) 1850 (Year)

7. AGE: 65 Yrs. 1 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Italy.

10. NAME OF FATHER: Antone Peterlin.

11. BIRTHPLACE OF FATHER (State or Country): Italy.

12. MAIDEN NAME OF MOTHER: Mary Sella.

13. BIRTHPLACE OF MOTHER (State or Country): Italy.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jerome Peterlin.

(Address) Bellevue.

15. Filed Jan 13 1916

R. D. Harris
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 12. (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191...,

that I last saw h— alive on ——— 191...,

and that death occured on the date stated above, at 6 8 M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Found Dead

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. D. Harris M. D.

Jan 13th 1916 (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bellevue — DATE OF BURIAL: Jan 15 1916

20. ~~UNDERTAKER~~: R. D. Harris — ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BKBS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bonneville

Primary Registration District No. 2170

File No. 13481

City of Idaho Falls

(No. ....., ... St.)

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME LeRay Peasley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH

Dec (Month) 19 (Day) 1914 (Year)

7. AGE

1 yrs. 1 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idoho Falls

10. NAME OF FATHER Allie Peasley

11. BIRTHPLACE OF FATHER (State or Country) Mich.

12. MAIDEN NAME OF MOTHER Effie Dutton

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Allie Peasley

(Address) Idoho Falls, Ida

15.

Filed Jan 22 1916 C E Kimmel Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7th 1916, to Jan 21st 1916; that I last saw h[illegible] alive on Jan 20th 1916 and that death occurred on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 13 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. R. Dobrynin M. D.

1/20 1916 (Address) Idoho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idoho Falls | DATE OF BURIAL: 1-21 1916

20. UNDERTAKER: C E Kimmel | ADDRESS: Ido. Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13482
Registered No. 6

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2 1 0
(No. ..... , ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen E Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH
July (Month) 15 (Day) 1916 (Year)

7. AGE
0 yrs. 7 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Ernest Brown

11. BIRTHPLACE OF FATHER (State or Country) Ernest Brown

12. MAIDEN NAME OF MOTHER Olive E Dunick

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E Brown
(Address) Marysvale

15. Filed Feb 1916 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31st 1916, to Feb 1st 1916, that I last saw h[illegible] alive on Feb 1st 1916, and that death occurred on the date stated above, at [illegible] A.M.

The CAUSE OF DEATH* was as follows:
Sarcoma Kidney

(Duration) ..... yrs. 3 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. P. Dodgenuck M. D.
2/1 1916 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ashton — DATE OF BURIAL: 2/ 1916

20. UNDERTAKER: C E Dunwoody — ADDRESS: Ida Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2150
File No. 13483
Registered No. 4

1. PLACE OF DEATH.
County of Canewille
City of Idaho Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eliz. Billman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Sept 7th 1845 (Month) (Day) (Year)

7. AGE: 70 yrs. 3 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: George Barnes

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jane Howard

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Minnie Lakeman
(Address) Idaho Falls

15. Filed Jan 19 1916 Wm Linnard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January 14 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1915, to January 12 1916 that I last saw h.. alive on Jan. 12 1916 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Tabular Nut Lesion

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Pulmonary Tb

..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wm Linnard M. D.
1/19 1916 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Acon Ida. DATE OF BURIAL: 1/19 1916

20. UNDERTAKER: C. Dunwoody ADDRESS: Ida Falls

SYMS-YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Ida. Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13
Primary Registration District No. 215-0
(No. ....., ... St.)

File No. 13485
Registered No. 1
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peder Erickson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ? (Month) ? (Day) 1857 (Year)

7. AGE: 58 yrs. ? mos. ? ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G G Dunwoody
(Address) Ida Falls Ida

15. Filed Jan 15 1916 W Fennand Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1916, to Jan 12 1916, that I last saw him alive on Jan 12 1916, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) 2 yrs. ✓ mos. ✓ ds.

Contributory (Secondary) ✓
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T H Coulthard M. D.
1-14-1916 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls, Ida | DATE OF BURIAL: 1-14 1916

20. UNDERTAKER: G G Dunwoody | ADDRESS: Ida Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13
Primary Registration District No. 21-0
(No. ....., ... St.)

File No. 13486
Registered No. 1
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harvey Bloxham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH
Dec (Month) 15 (Day) 1903 (Year)

7. AGE
12 yrs. 1 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... at Home
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ucon Idaho

10. NAME OF FATHER J C Bloxham

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Eliz. Davis

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Bloxham - By Phone
(Address) Ucon Ida

15.
Filed Jan 17 1916 Lou Tunnam Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Gun Shot Wound
accidental

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Dunwoody M.D.
1/17 1916 (Address) Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Ucon Ida
DATE OF BURIAL: 1/19 1916

20. UNDERTAKER: C E Dunwoody
ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 73
County of Bonneville Primary Registration District No. 2100
City of Idaho Falls (No. ....., ... St.)
File No. 13487
Registered No. 10
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara M Kellum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Mch. (Month) 4 (Day) 1871 (Year)

7. AGE: 44 yrs. 11 mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Neb.

10. NAME OF FATHER: Geo. W. Drawns

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER: Clark

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James O Kellum
(Address) Idaho Falls, Ida

15. Filed Feb 7 1916 Chas Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28th 1916, to Feb 4th 1916, that I last saw her alive on Feb 4th 1916, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the bowel.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hallisten, M. D.
2/8 1916 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Linna. Mont | DATE OF BURIAL: Feb 7 1916

20. UNDERTAKER: C. B. Linwood | ADDRESS: Ida Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13488

Registered No. 9

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 21d-c

(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Martin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 29 (Day) 1868 (Year)

7. AGE: 47 yrs. 10 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Restaurant Keeper
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Covington, Kentucky

10. NAME OF FATHER: William Martin

11. BIRTHPLACE OF FATHER (State or Country): ——

12. MAIDEN NAME OF MOTHER: Hubbard

13. BIRTHPLACE OF MOTHER (State or Country): ——

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minetta Martin wife.

(Address) Idaho Falls

15.

Filed Feb 3 1916

C. A. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gun Shot wound.

Self inflicted.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Hammond Coroner M. D.

2/3 1916 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery — DATE OF BURIAL: Feb 3 1916

20. UNDERTAKER: G. H. Hunt — ADDRESS: Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonneville
City of Ida Falls
(No. ..... St.)

Registration District No. 73
Primary Registration District No. 210

File No. 13489
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Deasons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Jan (Month) 9- (Day) 1858 (Year)

7. AGE: 57 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: David Deasons Sr

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Phoeb S. Foss

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fabyan S. Deasons
(Address) Bonneville Idaho

15. Filed Sept 1914

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1914, to Jan 20 1914, that I last saw h alive on Jan 20 1914 and that death occured on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Chronic Bright's Disease
.....
.....
.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) S. S. Fuller M. D.
1/22 1914 (Address) Ida Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverside Cem — DATE OF BURIAL: Jan 22 1914

20. UNDERTAKER: W. H. Gould — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2107
(No. ....., ... St.)

File No. 13490
Registered No. 7
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nielsigine Marie Petersen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
Oct (Month) 30 (Day) 1862 (Year)

7. AGE
53 yrs. 2 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER B K Knudsen

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Benson

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Linwoodey
(Address) Idoho Falls, Ida

15.
Filed Feb 1 191 6 Geo Summard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 9:30 A. M.
The CAUSE OF DEATH* was as follows:

Tuberculosis Lungs
No Medical Attendance

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Summard M. D.
2/1 1916 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rigby Ida	1-26 1916

20. UNDERTAKER	ADDRESS
C E Linwoodey	Idoho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2446
(No. ....., ... St.)

File No. 13492
Registered No. 2
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Sarah Cole

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: May 20th 1833
(Month) (Day) (Year)
82 8 11

7. AGE: 82 yrs. 8 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Joseph Applegate

11. BIRTHPLACE OF FATHER (State or Country): New Jersey

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ella Durand
(Address) Salmon Idaho

15. Filed Feb. 3 1916 Ed Hendon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 1, 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1915, to Jany 31 1916, that I last saw her alive on Jany 31 1916, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Old Age

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. D. Wright M. D.

2/2 1916 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 2-2nd 1916

20. UNDERTAKER: W C Hoelle — ADDRESS: Salmon Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
(No. ..... St.)

File No. 13493
Registered No. One

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Lemhi
City of May

2. FULL NAME Mrs. Myrtle Cleveland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced
6. DATE OF BIRTH. March (Month) 17 (Day) 1886 (Year)
7. AGE: 29 Yrs. 10 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): Missouri
10. NAME OF FATHER: George Grubb
11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania
12. MAIDEN NAME OF MOTHER: Frances Crain
13. BIRTHPLACE OF MOTHER (State or Country): Illinois
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs R Mon Ks
(Address) May Ida.
15. Filed Feb 7, 1916 Saloma Cleveland Deputy Local Registrar
Edith D. Hendon-Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 29 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan. 3rd. 1916, to Jan. 29, 116 191, that I last saw he alive on Jan. 29th 1916, and that death occured on the date stated above, at 3 p M.
The CAUSE OF DEATH* was as follows:
Influenza
(Duration) Yrs. 1 mos. ds.
Contributory (Secondary) Septicopyemia.
(Duration) yrs. 1 mos. ds.
(Signed) O. Hartley M. D.
1/30 1916 (Address) Challis, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: May, Idaho. DATE OF BURIAL: Jan. 31st 1916
20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5. 12½M.—7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Murray
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 122
Primary Registration District No. 3202
(No. ....., ... St.)

File No. 13494
Registered No. 1

2. FULL NAME Samuel Green

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: ..... (Month) ..... 1 (Day) ..... (Year)

7. AGE: 60 yrs. — mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mine Owner
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R J White
(Address) Wallace

15.
Filed 1/29 1916 H C Mowery
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at 3.20 A.M.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
.....
.....
..... (Duration) Several yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas R. Mowry Coroner
1/27 1916 (Address) [redacted] Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place Murray Idaho In the
of death — yrs. — mos. 5 ds. State — yrs. — mos. — ds.
Where was disease contracted,
If not at place of death?
Former or usual residence New York City

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Jany 26 1916

20. UNDERTAKER: B E Worstell — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13495

Registered No. 4

1. PLACE OF DEATH.

County of Madison

City of Sugar

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel H. Southwick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Oct (Month) 31 (Day) 1891 (Year)

7. AGE 24 Yrs. 2 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Samuel H. Southwick

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Lethe Austin

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lethe Southwick
(Address) Sugar, Ida

15. Filed 1-20 1916 J. E. Cooper Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916, to Jan 18 1916, that I last saw him alive on Jan 19 1916, and that death occured on the date stated above, at 12:35 P.M.

The CAUSE OF DEATH* was as follows:
Embolism Following
Typhoid Pneumonia

(Duration) — Yrs. — mos. 18 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Cooper M. D.

1916 (Address) Sugar Ida.

*State the DISEASE CAUSING DEATH; or if deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sugar City — DATE OF BURIAL Jan 21 1916

20. UNDERTAKER T. M. Williams — ADDRESS Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 13496
Registered No. 5
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leland Dwight Fullmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH Feb. (Month) 9 (Day) 1896 (Year)

7. AGE 20 yrs. 11 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Student
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER B W Fullmer

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Luenda Munro

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carrie Daniels
(Address) Rexburg

15. Filed JAN 27 1916 191
G. L. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan. (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1916, to Jan. 26 1916, that I last saw him alive on Jan 15 1916, and that death occurred on the date stated above, at 6 00 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) yrs. 4 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Joseph Walker M. D.
19 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Clawson	1/31 1916

20. UNDERTAKER	ADDRESS
J Rigby	Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 102
Primary Registration District No. 2178
File No. 13497
Registered No. 7

1. PLACE OF DEATH.
County of Mad.
City of Rexburg (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nyram S. Dudley
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Sept. (Month) 30 (Day) 1859 (Year)

7. AGE: 56 yrs. 4 mos. 5 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Alvin N. Dudley

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Mary A. Robinson

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Delia Neilson
(Address) Rexburg

15. Filed 2-7 1916 G. G. Gee Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Cancer of face
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. G. Gee M. D.
19..... (Address) as Local Registrar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg	2-7 1916

20. UNDERTAKER	ADDRESS
John Phillips	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 13498
Registered No. 3

1. PLACE OF DEATH.
County of Madison
City of Rigby (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna Eva Hoopes
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Sept (Month) 30 (Day) 1908 (Year)

7. AGE: 7 yrs. 3 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at School
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: E. H. Hoopes

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Mary Jackson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Hoopes
(Address)

15. Filed 1-8 1916 G. E. Epe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1916 to Jan 8 1916, that I last saw her alive on Jan 8 1916, and that death occurred on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:
Acute toxemia Laryngitis

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos Walker M. D.
19 (Address) Rigby

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sugar City	Jan 10 1916

20. UNDERTAKER	ADDRESS
F. M. Williams	Rigby Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Mad[illegible]
City of Hilliard
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 13500
Registered No. 6
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME [illegible] Knapp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Feb. (Month) 17 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 7 weeks
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Hilliard

10. NAME OF FATHER Justin W. Knapp

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mabel F. Hale

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Justin W. Knapp

15. Filed 2-4 1916 G. L. Estes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 4 (Day) 16 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 17 1916, to July 3 1916, that I last saw h[illegible] alive on Dec 20 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Whooping Cough
.....
.....
(Duration) ..... yrs. 1 mos. ..... ds.
Contributory (Secondary) Exhaustion & Bronchitis by Pneumonia
(Duration) ..... yrs. 0 mos. ..... ds.

(Signed) G. L. Estes M. D.
19 ..... (Address) Ex Local Registrar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 2/5 1916

20. UNDERTAKER: John Phillips — ADDRESS: Rex

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 13501
Registered No. 2
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Keith Elmo Morris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Jan (Month) 1 (Day) 1916 (Year)

7. AGE
..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Hyrum P. Morris

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Myrtle Jones

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. Morris
(Address) Rexburg Idaho

15.
Filed 1-4 1916
G. L. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
1 (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-1 1916, to 1-3 1916, that I last saw h.. alive on 1-3 1916, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Asphyxia from pressure of hyperthrophied thyroid gland
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. L. Espe M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg	Jan 4 1916
20. UNDERTAKER	**ADDRESS**
F. M. Williams	Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5, 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13502

Registered No. 36

1. PLACE OF DEATH.
County of Bear Lake
City of Paris
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. Paul Arthur St.)

2. FULL NAME Ernest Paul Strobell

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 2 (Day) 1915 (Year)

7. AGE: yrs. 6 mos. 12 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Paris

10. NAME OF FATHER: Ernest Paul Strobell

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Meta Kehlhorn

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paris Ida Paul Strobell
(Address)

15. Filed 2-10- 1916 P. J. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....191..., to ....191...,
that I last saw h....alive on ....191...,
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia (2)
These people did not have a doctor thinking baby was sick,
(Duration) ....yrs. ....mos. ....ds.

Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) P. J. Sutton M. D.
Jan 15 1916 (Address) Paris Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Paris
DATE OF BURIAL: Jan 16 1916

20. UNDERTAKER: Bishop Poulson
ADDRESS: Paris Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13503
Registered No.

1. PLACE OF DEATH. Registration District No. 49
County of Idaho Primary Registration District No. 2128
City of Kamiah, Vicin (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Frazier

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	married

6. DATE OF BIRTH: Aug (Month) 27 (Day) 1876 (Year)

7. AGE: 39 yrs. 4 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: George W. Maguire

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Josephine Miller

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lizzie Davis
(Address) Kamiah Idaho

15. Filed Feb. 2nd 1916 W.J. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) Feb. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/1 1916, to same day 1916 that I last saw her alive on same day 1916 and that death occurred on the date stated above, at 12-M.

The CAUSE OF DEATH* was as follows:
Post partum hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W.J. McMahan M. D.
2/2/ 1916 (Address) Kamiah, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodland, Idaho.	Feb. 5th 1916
20. UNDERTAKER	**ADDRESS**
C.J. Johnson	Kamiah, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 44
Primary Registration District No. 2121
File No. 165
Registered No. 13505

1. PLACE OF DEATH.
County of Owyhee
City of Bruneau (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rudolph Fromm
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct. 29 (Month) (Day) 1897 (Year)

7. AGE: 18 yrs. 2 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Charles Fromm

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Augusta Shultz

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul Fromm
(Address) Riddle Ida.

15. Filed Jan 3 1916 J C Bartlett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. 2nd (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14 1915 to Jan 2 1916, that I last saw him alive on Jan 2 1916, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. 2 mos. 4 ds.

Contributory (Secondary) Abscess of Abscesses

(Duration) yrs. mos. 18 ds.

(Signed) J C Bartlett M. D.
Jan 3 1916 (Address) Bruneau Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Bruneau Idaho | DATE OF BURIAL: Jan 3 1916

20. UNDERTAKER: D R Hyde | ADDRESS: Bruneau Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13506

Registered No. 65

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 1502 E Ida St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Warren Gish

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug. (Month) 27 (Day) 1851 (Year)

7. AGE: 64 Yrs. 6 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Geo. W Gish

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Sarah Jane Riddle

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Jones

(Address) Boise Idaho

15. Filed 2/29 191 6

E. S. Eaton
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Feb (Month) 28½ (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 27 1916, to Feb 28½ 1916, that I last saw him alive on Feb 28½ 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Hunt Bruce M. D.

2-29 1916. (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill | DATE OF BURIAL: Mar. 1 1916

20. UNDERTAKER: Troy Summers | ADDRESS: Boise

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1004
File No. 13507
Registered No. 64

1. PLACE OF DEATH.
County of Ada
City of Boise Idaho
(No. [illegible] Jefferson St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Aetna Grant Gallup

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
February 22nd 1872
(Month) (Day) (Year)

7. AGE
44 yrs. 6 mos. 6 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Baker
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Wisconsin Dane Co.

10. NAME OF FATHER Julian Eugene Gallup

11. BIRTHPLACE OF FATHER
(State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Emma Waite

13. BIRTHPLACE OF MOTHER
(State or Country) Wisconsin.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maude Davis
(Address) Highland California

15.
Filed 3/29 191 8
E. J. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
February 28th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 18 1916, to Feby 28 1916, that I last saw h... alive on Feby 28 1916, and that death occurred on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:
Diabetic Coma
(Duration) ... yrs. ... mos. 10 ds.
Contributory Diabetes
(Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) James L. Alexander M. D.
3/29 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery Boise Idaho	March 1st 1916

20. UNDERTAKER	ADDRESS
Schreiber & Hodenfield	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13508

Registered No. 63

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ellen Whitlock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 23 (Day) 1909 (Year)

7. AGE: 6 Yrs. 4 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada Co Idaho

10. NAME OF FATHER: David E Whitlock

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Emma Shawver

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lauren Hodd

(Address) Boise

15. Filed 2/28 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1916, to Feb 26 1916, that I last saw h[illegible] alive on Feb 26 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) Yrs. mos. 8 ds.

Contributory (Secondary) Acute Nephritis

(Duration yrs. mos. [illegible] ds.

(Signed) W. S. Rutan M. D.

2-28 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 6 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Ada County, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/29 1916

20. UNDERTAKER: Schreiber & Siddenfaden — ADDRESS: Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. A 6888. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. [redacted] 1004

(No. 1007 State St.)

File No. 13509

Registered No. 62

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jane Taggart Eagleson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb (Month) 7 (Day) 1846 (Year)

7. AGE: 70 Yrs. — Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Home Keeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) O[redacted] Harrison Co.

10. NAME OF FATHER Alexander Taggart

11. BIRTHPLACE OF FATHER (State or Country) Ohio, Harrison Co.

12. MAIDEN NAME OF MOTHER Sarah Mansfield

13. BIRTHPLACE OF MOTHER (State or Country) Ohio Jefferson Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. G. Eagleson
(Address) 1007 State St. Boise Idaho

15. 2/25 Filed 191 6

E J Cahn
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 24th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1915, to Feb 24th 1916, that I last saw her alive on Feb 24 1916, and that death occured on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:
Edema of Lungs —
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteriosclerosis - with high blood pressure
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Taylor M. D.
Feb 24 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/26 1916

20. UNDERTAKER: Schneider & Hidenfelder — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 13510

Registered No. 61

County of Ada

City of Boise (No. 1416 N. 13 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph E Woods

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. January (Month) 4 (Day) 1833 (Year)

7. AGE ....Yrs. 83 ....Mos. 1 ....ds. 18

IF LESS than 1 day how many ....hrs. or ....min.

8. OCCUPATION

(a) Trade, profession or particular kind of work. Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) ....

9. BIRTHPLACE (State or Country) Maine

10. NAME OF FATHER David Woods

11. BIRTHPLACE OF FATHER (State or Country) American

12. MAIDEN NAME OF MOTHER Judith Savage

13. BIRTHPLACE OF MOTHER (State or Country) New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wiley E Gate

(Address) 1412 N. 13th St Boise Idaho

15. Filed 2/24 19 16

E. F. Cahn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1916, to May 22 1916, that I last saw him alive on May 22 1916, and that death occured on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:

Cerebro sclerosis

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) ....

....(Duration ....yrs. ....mos. ....ds.

(Signed) Geo Callaway M. D.

19.... (Address) ....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/24 1916

20. UNDERTAKER: Schneider & Lindquist — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 1351

Registered No. 60

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 118 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur G. McConnell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. (Month) Jan (Day) 13 (Year) 1879

7. AGE: 37 Yrs. 1 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER D. C. McConnell

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Elizabeth Hall

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles E. McConnell
(Address) Twin Falls Ida.

15. Filed 2/23 1916

E. J. Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Feby (Day) 21 (Year) 1916

17. I HEREBY CERTIFY, That I attended deceased from Feby 17 1916, to Feby 21 1916, that I last saw h..... alive on Feby 21 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cerebral meningitis

(Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary) .....
Duration ..... yrs. ..... mos. ..... ds.

(Signed) James J. Ellert M. D.
2/23 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill T

DATE OF BURIAL: Feb. 23 1916

20. UNDERTAKER: Gray & Summers

ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada — Registration District No. 12

City of Boise — Primary Registration District No. 1004

(No. 410 Hite St.)

File No. 13512

Registered No. 59

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Brown Cornish.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White-American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 12 (Day) 1886 (Year)

7. AGE: 29 yrs. 10 mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Black Hawk.

10. NAME OF FATHER: John Brown Cornish

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Margaret Elizabeth Hathaway

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret E. Cornish

(Address) Meridian RD 2.

15.

Filed 2/23 1916

E. L. Culton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Febr. (Month) 20th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-16- Wednesday 1916, to 2-20th 1916, that I last saw h.s.m. alive on Febr-19- 1916, and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia (Lobar) — Hemorrhage from throat and other Complications.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Intercurrent infection

(Duration) Indefinite yrs. ..... mos. ..... ds.

(Signed) C. L. Dutton M. D.

2-20 1916 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 3 days. In State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence: Meridian & Boise

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL: Feb. 24 1916

20. UNDERTAKER: Overton & Eidemiller — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PTRS. & BDRS. 19780

FORM V. S. No. b-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13513

Registered No. 58

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. St. Alphonsus Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank M. Graham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May — 1881 (Month) (Day) (Year)

7. AGE: 34 Yrs. 8 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: James L. Graham

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Rebecca M. Peck.

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lewis F. Graham
(Address) .....

15. Filed 2/23 1916

E. L. Pahn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 21 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1916, to Feb 21 1916, that I last saw him alive on Feb 20 1916 and that death occured on the date stated above, at 1:20 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(Duration) 1 Yrs. 1 mos. 2 ds.

Contributory (Secondary): Influenza

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Jos. F. Nemyer M. D.

2/23 1916 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill. DATE OF BURIAL: Feb 23 1916

20. UNDERTAKER: Fry & Summers. ADDRESS: Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13514
Registered No. 57

1. PLACE OF DEATH.
County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Ireland Congdon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. (Month) 9 (Day) 1908 (Year)

7. AGE: 7 Yrs. 5 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER John T. Congdon

11. BIRTHPLACE OF FATHER (State or Country) New York.

12. MAIDEN NAME OF MOTHER Mary D. Ireland.

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. J. McSpaden
(Address) Pocatello Idaho

15. Filed 2/19 6 191...
E. J. Patton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 17th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 8th 1916, to Feb 17th 1916, that I last saw h. 1/2 m. alive on Feb 17th 1916 and that death occured on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) — Yrs. 2 or less mos. — ds.

Contributory (Secondary) ..... (Duration ... yrs. ... mos. ... ds.

(Signed) J. M. Taylor M. D.
2/18 1916 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Feb 19 1916

20. UNDERTAKER: Gray & Summers ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13515

Registered No. 56

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 110 E. State St.)

Registration District No.

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sadie M. Bourns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (write the word.): Single

6. DATE OF BIRTH. Sept (Month) 18 (Day) 1883 (Year)

7. AGE: 32 Yrs. 5 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: James Bourns

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Elizabeth Ruff

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Bourns
(Address) Boise Idaho

15.
Filed 2/18 191 6
E. F. Cutter
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 21 1916, to July 18 1916, that I last saw h alive on July 18 1916 and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

General Septicaemia
following La Grippe
(Duration) Yrs. 1 mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) James L. Blount M. D.
July 18 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs..mos..days In the State ..yrs..mos..days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Waterloo Iowa — DATE OF BURIAL: 7/21 191 6

20. UNDERTAKER: Gray & Hummel — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 13517
Registered No. 54

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. St. Alphonsus Hosp. St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME R. Eleanor Bickley.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: 7.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or widowed)
6. DATE OF BIRTH: Sep (Month) 17 (Day) 1877 (Year)
7. AGE: 38 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Missouri
10. NAME OF FATHER: William Wood.
11. BIRTHPLACE OF FATHER (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Mary Wright
13. BIRTHPLACE OF MOTHER (State or Country): Illinois.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. S. Bickley
(Address) Box 241 - Phone 2439 W.

15. Filed 2/15 6 191..
E. S. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 14 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1916, to Feb 14 1916, that I last saw h-r alive on Feb 14 1916, and that death occured on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W. S. Eaton M. D.
2-15 1916. (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. — DATE OF BURIAL: Feb 20 1916
20. UNDERTAKER: Fry & Summers. — ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & ENGR. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 13518
Registered No. 53

1. PLACE OF DEATH.
County of Ada
City of South Boise (No. 5 Th & Grant St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harmon E Eastman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH
Oct (Month) 16 (Day) 1883 (Year)

7. AGE
80 yrs. 2 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER — Eastman

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D H Eastman
(Address) Eagle Idaho

15.
Filed 2/14 1916
C. F. Culver
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
February (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 8 1916, to Feb 12 1916
that I last saw h im alive on Feb 12 1916
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Senility
(Duration) yrs. mos. ds.
Contributory (Secondary) Bronchitis
(Duration) yrs. mos. ds.

(Signed) Wm H. Tukey M. D.
2/15 1916 (Address) 315 Overland, Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill	Feb 15 1916

20. UNDERTAKER	ADDRESS
Fry & Summers	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 12519
Registered No. 52

1. PLACE OF DEATH.
County of Ada.
City of Boise. (No. 1016 No 13 St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George L. Lorimer.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
m.	White.	Married (or Widowed).

6. DATE OF BIRTH: May (Month) 27. (Day) 1873 (Year)

7. AGE: 42 yrs. 8 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Bartender.
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: George L. Lorimer.

11. BIRTHPLACE OF FATHER (State or Country): Illinois.

12. MAIDEN NAME OF MOTHER: Mary E. Kirkham

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. R. Lorimer
(Address) .....

15. Filed 2/14 191 .....
E. J. Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1915, to Feb 12 1916, that I last saw h[illegible] alive on Feb 6 1916 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
General Paresis.

(Duration) 1 yrs. mos. ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. [illegible] M. D.
2/14 1916. (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Feb 14 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital St.)

File No. 13520
Registered No. 51
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Flora M. Timm.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
F.	White	Married (the word.)

6. DATE OF BIRTH: Dec 29 (Month) (Day) 1874 (Year)

7. AGE: 41 yrs. 1 mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois.

10. NAME OF FATHER: Joseph Crow.

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable.

12. MAIDEN NAME OF MOTHER: Not Obtainable.

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herman M Timm
(Address)

15. Filed 2/13 191 C. F. Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby 12 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 10 1916, to Feby 12 1916, that I last saw her alive on Feby 12 1916, and that death occurred on the date stated above, at 4 1/2 P.M.

The CAUSE OF DEATH* was as follows:
Placenta Previa
Hemorrhage

(Duration) yrs. mos. 1 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) James L Stewart M. D.
2/13 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parma Idaho. DATE OF BURIAL: 191

20. UNDERTAKER: Fry & Summers ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada
City of Boise
(No. 410 States St.)

Registration District No. 2
Primary Registration District No. 1004

File No. 13521
Registered No. 504

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ina Pierce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. July (Month) 8 (Day) 1888 (Year)
7. AGE: 27 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Ills.
10. NAME OF FATHER: Willis Dayton
11. BIRTHPLACE OF FATHER (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Lilly Bancroft
13. BIRTHPLACE OF MOTHER (State or Country): Ills.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charlotte Dayton
(Address) Emmett Idaho.
15. Filed 2/12 191 C. F. Lutz Local Registrar

SYMS - YORK CO., PTRS. & BNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 12th 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 6th 1916, to Feb 12th 1916, that I last saw her alive on Feb 12th 1916, and that death occured on the date stated above, at 1230 A.M.
The CAUSE OF DEATH* was as follows:
Double Pneumonia
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Valvular heart disease
(Duration many) ..... yrs. ..... mos. ..... ds.
(Signed) L. P. McCalla M. D.
2/12 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence Emmett, Idaho

19. PLACE OF BURIAL OR REMOVAL: Emmett Ida. | DATE OF BURIAL: 2/14 1916
20. UNDERTAKER: Schreiber & Siebenfaden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Dr. McCalla

Borck

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13522
Registered No. 49

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1311 N 21 St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1004

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME May Ballou

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 13 (Day) 1866 (Year)

7. AGE: 49 yrs. 4 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: — Sledge

11. BIRTHPLACE OF FATHER (State or Country): not obtainable.

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence C. Ballou
(Address) Boise, Idaho

15. Filed 2/12 1916
C. S. Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 11th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31st 1916, to Feb 11th 1916, that I last saw h[illegible] alive on Feb 11th 1916 and that death occurred on the date stated above, at 12:35 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) yrs. mos. 12 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Stan Boutz M. D.
2-12 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: Feb 13 1916

20. UNDERTAKER: Fry & Summers
ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. ____

Primary Registration District No. 1004

File No. 13523

Registered No. 46

County of Ada

City of Boise (No. 110 East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME China Jack

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	Yellow	Single

6. DATE OF BIRTH

(Month) (Day) 1842 (Year)

7. AGE

74 yrs. ____ mos. ____ ds.

IF LESS than 1 day how many ____ hrs. or ____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry business, or dstablishment in which employed (or employer) ____

9. BIRTHPLACE (State or Country) China

10. NAME OF FATHER not obtainable

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____

(Address) Charley Sing Lee
Boise Ida

15. Filed 2/10 1916

E. J. Lairn
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 8

(Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7th 1916, to Feb 8th 1916, that I last saw him alive on Feb 8th 1916, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Apoplexy

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. Lauterbach M. D.

2-10 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Chinese Cemetery	Feb. 22 1916

20. UNDERTAKER	ADDRESS
Schreiber & Siddenfaden	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13524

Registered No. 44

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada.

City of Boise

(No. 50 Boise St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James T. Russell.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. — (Month) — (Day) 1858 (Year)

7. AGE: 58 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Robert M. Russell.

11. BIRTHPLACE OF FATHER (State or Country): Tennessee.

12. MAIDEN NAME OF MOTHER: Fannie January.

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sue Hart

(Address)

15. Filed 2/9 191..

E. L. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1916, to Feb 191 7, that I last saw h... alive on ... 191..., and that death occured on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

asthma Cardiac

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) Geo Grant M. D.

2/9 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill. DATE OF BURIAL: Feb 9 1916

20. UNDERTAKER: Frys & Summers ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 1004

(No. South Boise — Stahl)

File No. 13525

Registered No. 43

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fredrick Stahl.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June 2nd 1838 (Month) (Day) (Year)

7. AGE: 77 yrs. 7 mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mervin Stahl

(Address)

15. Filed 2/9 191 E. L. Carlson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 7th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Old age and Senility has been quite feable for the past 5 yrs.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

no Doctor (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. G. Stahl M. D.
Son of Deceased

19.... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/9 1916

20. UNDERTAKER: Schreiber & Redemsden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

Titus

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

(No. St. Alphonsus Hospital St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13526

Registered No. 42

1. PLACE OF DEATH.

County of Ada.

City of Boise.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma W. Hamilton.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH. Nov. 27 (Month) (Day) 1859 (Year)

7. AGE: 56 Yrs. 2 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): ———

9. BIRTHPLACE (State or Country) West Virginia

10. NAME OF FATHER John Snyder.

11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable.

12. MAIDEN NAME OF MOTHER Mary Semple.

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John D. Hamilton

(Address) Boise Idaho

15. Filed 2/8 191 — E. J. Collins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 7 (Month) (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1915, to Feb 7 191 6, that I last saw h.. alive on Feb 7 191 6, and that death occured on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(Duration) years 6 mos. ds.

Contributory (Secondary) Asthma

(Duration) yrs. — mos. ds.

(Signed) W. E. Zeller M. D.

12-8 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairmont W. Va. DATE OF BURIAL: 2/14 191 6

20. UNDERTAKER: Frye Summers ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 505, South 13th St.)

File No. 13527
Registered No. 41
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas R Sullivan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec. (Month) 13 (Day) 1892 (Year)

7. AGE: 23 yrs. 1 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lobman
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: John Sullivan

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Mary Hoey

13. BIRTHPLACE OF MOTHER (State or Country): Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. J. Guyman
(Address)

15. Filed 2/5 191 E. X. Colton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1915, to Jan 3 1916 that I last saw him alive on Jan 2 1916, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Maurice Saltman M. D.
1/4 19 16 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 2/6 1916

20. UNDERTAKER: Schreiber & Siebenfaden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 13528

Registered No. 40

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis Plesh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): ~~unknown~~

6. DATE OF BIRTH: Unknown (Month) 1 (Day) (Year)

7. AGE: about 38 yrs. mos. ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Not obtainable
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A Schreiber

(Address) Boise

15. Filed 2/5 191

E. J. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 3 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1916 to Feb 3 1916 that I last saw h— alive on Feb 3 1916 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) P. E. Shuck M. D.

Feb 3 1916 (Address) P. E. Shuck

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery | DATE OF BURIAL: Feb 7 1916

20. UNDERTAKER: Schreiber & Anderson | ADDRESS: Boise

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

Revised

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 13530

Registered No. .....

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. St Lukes Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Louise Hitchcock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb 1 (Month) 1 (Day) 916 (Year)

7. AGE: ..... Yrs. ..... Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Boise Ida.

10. NAME OF FATHER: D E. Hitchcock

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Mae Smith

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D E Hitchcock

(Address) Haddock Ida

15. 2/4 Filed ..... 191.....

E. F. Calvin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1916, to July 3 1916, that I last saw h..... alive on July 3 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Immaturity (Premature)

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James F Stewart M. D.

7/4 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: July 5 1916

20. UNDERTAKER: Troy Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

6Y88 - YORK CO., PTRS. & SHEA. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 1911, Main St.)

Registration District No. 2

Primary Registration District No. 1004

File No. 13531

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Elizabeth Potter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. April (Month) 6 (Day) 1830 (Year)

7. AGE: 85 Yrs. 9 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Beecher

11. BIRTHPLACE OF FATHER (State or Country): Not obtainable

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A Milton Rull

(Address) 1911 N 7 Boise Ida

15. Filed 2/I 191 6

E. J. Bunn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1916, to Jan 29 1916, that I last saw h... alive on ... 191..., and that death occured on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Brights disease

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) Geo Calvert M. D.

19.... (Address) ...

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence Lewiston Ida

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: Feb. 2 1916

20. UNDERTAKER: Schreiber & Hidenfeldt — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13532

Registered No. 36

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

Registration District No.

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace H. Chitwood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 14 (Day) 1887 (Year)

7. AGE: 34 Yrs. 6 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wabasso Wis

10. NAME OF FATHER: Edward M. Clark

11. BIRTHPLACE OF FATHER (State or Country): Ans.

12. MAIDEN NAME OF MOTHER: Minnie R. Kelly

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James L. Chitwood

(Address) Boise R. F. D. 4

15. Filed 2/I 191 6

E. J. Colvin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916, to Jan 31 1916, that I last saw h alive on Jan 31 1916, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Post operative illness

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Maurice Fallon M. D.

2/1 1916 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/3 1916

20. UNDERTAKER: Schreiber & Redemske — ADDRESS: Boise

Fallon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BARS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 13533
Registered No. 8

1. PLACE OF DEATH.
County of Ada
City of Near Boise (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melba Estes Sibley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH: Feb (Month) 5 (Day) 1916 (Year)

7. AGE: — yrs. — mos. 8½ ds. IF LESS than 1 day how many ..... hm. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Irvin Sibley

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Alice Tice

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. L. Bumgardner
(Address) Boise

15. Filed Feb 15 1916 C. S. Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1916 to ..... 191.
that I last saw her alive on Feb 14 1916
and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature Birth

(Duration) ..... yrs. ..... mos. Coroners

(Signed) Clyde E. Summers M. D.

2/15 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill | DATE OF BURIAL: Feb 16 1916

20. UNDERTAKER: Fry & Summers | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 6-15 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 13534
Registered No. 9

1. PLACE OF DEATH.
County of Ada
City of Boise (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Betty Lucile Snider

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Feb (Month) 21 (Day) 1916 (Year)
7. AGE: ... Yrs. ... Mos. 2 ds. IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Boise Ida
10. NAME OF FATHER: C. A. Snider.
11. BIRTHPLACE OF FATHER (State or Country): Neb
12. MAIDEN NAME OF MOTHER: Alice May.
13. BIRTHPLACE OF MOTHER (State or Country): U. Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. A. Snider
(Address) Box 833 Boise Ida
15. Filed Feb 23rd, 1916 W. W. Cluthe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 23 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1916, to Feb 23 1916, that I last saw h[er] alive on Feb 23 1916 and that death occured on the date stated above, at 3 A.M.
The CAUSE OF DEATH* was as follows: Congenital heart disease
(Duration) ... Yrs. ... mos. 3 ds.
Contributory (Secondary)
(Duration ... Yrs. ... mos. ... ds.
(Signed) P. H. Glasscock M. D.
19.... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Feb 23 1916
20. UNDERTAKER: Troy Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 13536
Registered No. 3

1. PLACE OF DEATH.
County of Elmore
City of Mtn Home (No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Amy Walker Sumner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 13 (Day) 1884 (Year)

7. AGE: 31 yrs. 11 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: L. L. Walker

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Miriam Emily Luke

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. L. Sumner
(Address) Mountain Home

15. Filed Feb. 9th 1916 B. W. Walker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9 1915, to Feb 8 1916 that I last saw her alive on Feb 8 1916, and that death occurred on the date stated above, at 10 20 P.M.

The CAUSE OF DEATH* was as follows:
Hypostatic Congestion of Liver and Kidneys, Infection of Gall bladder, Jaundice
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary)
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. L. Draper M. D.
2-9 1916 (Address) Mtn Home, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home, Idaho
DATE OF BURIAL: Feb. 10 1916

20. UNDERTAKER: J. M. Cowen
ADDRESS: Mtn Home Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13537
Registered No. 14

1. PLACE OF DEATH.
County of Madison
City of Salem (No. ..., ...St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178

2. FULL NAME Helen Vernon Mortensen
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH
May (Month) 26 (Day) 1915 (Year)

7. AGE
yrs. 9 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Peter Mortensen

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Annie Mary Harris

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Mortensen
(Address) Salem, Idaho

15.
Filed 3/11 1916 G L Gaskill
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ...191..., to ...191...,
that I last saw h...alive on ...191...,
and that death occurred on the date stated above, at ...M.
The CAUSE OF DEATH* was as follows:
Meningitis
(Duration) ...yrs. ...mos. ...ds.
Contributory (Secondary) .....
(Duration) ...yrs. ...mos. ...ds.
(Signed) G L Gaskill M. D.
...19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg	March 11 1916

20. UNDERTAKER	ADDRESS
J. M. Williams	Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 34

County of Elmore

Primary Registration District No. 2020

City of Mountain Home Idaho (No. ....., ... St.)

File No. 13538

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ignacio Bidegaurla

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Spanish

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept (Month) 29 (Day) 1915 (Year)

7. AGE: ..... Yrs. 4 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... —

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Agapito Bidegaurla

11. BIRTHPLACE OF FATHER (State or Country) Spain Monastland

12. MAIDEN NAME OF MOTHER Mcaura

13. BIRTHPLACE OF MOTHER (State or Country) Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agapito Bidegaureta

(Address) Mountain Home Ida.

15. Filed Feb. 13th 1916 B.W. Mather Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 12th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12th 1916, to Feb. 12th 1916, that I last saw him alive on Feb. 12th 1916, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Entero - colitis

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) B.W. Mather M. D.

3/13 1916 (Address) Mtn. Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Idaho — DATE OF BURIAL: 14th 1916

20. UNDERTAKER: J.M. Bowers — ADDRESS: Mountain Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

6VMB - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13539

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Blaine

City of Fairfield

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58

Primary Registration District No. 2138

(No. ....., ... St.)

2. FULL NAME Mrs Amada Hobeley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Jan (Month) 13 (Day) 1842 (Year)

7. AGE: 74 yrs. — mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Hutchinson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: [redacted] Markland

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Hobley.
(Address) Fairfield Ida

15.
Filed 2-12-1916 D O Riggs
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1916, to Feb 11 1916, that I last saw her alive on Feb 6 1916, and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) — yrs. — mos. 20 ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) D O Riggs M. D.

2-12 1916 (Address) Fairfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canal Ida

DATE OF BURIAL: 2-13 1916

20. UNDERTAKER: Ely Markland

ADDRESS: Fairfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 13540
Registered No. 18
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bernice Eckersell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: July (Month) 18 (Day) 1915 (Year)

7. AGE: ..... yrs. 7 mos. 3 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Howard Eckersell

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Sarah Gald

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H Eckersell
(Address) Rexburg

15. Filed 2-22 1916 G F Teare Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1916, to Feb 21 1916, that I last saw her alive on Feb 20 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Whooping Cough

(Duration) ..... yrs. 1 mos. ..... ds.
Contributory (Secondary) Convulsions
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J Walker M. D.
19..... (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg	Feb 22 1916
20. UNDERTAKER	**ADDRESS**
F M Williams	Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Mad
City of Rex.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 13541
Registered No. 8
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julius D. Spaulding

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH
Jan. (Month) 7 (Day) 1872 (Year)

7. AGE
44 yrs. 1 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Labourer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Ira D. Spaulding

11. BIRTHPLACE OF FATHER (State or Country) America

12. MAIDEN NAME OF MOTHER Phebe Ann France

13. BIRTHPLACE OF MOTHER (State or Country) America.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Harper
(Address) Replogle Idaho

15.
Filed 2-26-1916 G. L. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb. (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Embolism

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. L. Espe M. D.
19.... (Address) as registrar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burton	Feb. 23 1916
20. UNDERTAKER	ADDRESS
John Phillips	Replogle

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 13542
Registered No. 9
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosina Ruffi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: July (Month) 24 (Day) 1847 (Year)

7. AGE: 68 yrs. 6 mos. 29 ds.
IF LESS than 1 day how many ..... *hrs.* or ..... *mins.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work — Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Switzerland

10. NAME OF FATHER Jacob Kernen

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Elizabeth Rapp

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jacob Ruffi
(Address) Rexburg

15.
Filed 2-23 1916 G. G. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1916, to Oct. 1916, that I last saw him alive on Oct 1916 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Mitral Stenosis

(Duration) many yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. Walker M. D.
19 ..... (Address) Lyman, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg | DATE OF BURIAL ..... 191...

20. UNDERTAKER: John Phillips | ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 13543
Registered No. 11

1. PLACE OF DEATH.
County of Franklin
City of St Charles (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Trupp

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: July (Month) 15 (Day) 1881 (Year)

7. AGE: 34 yrs. 6 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day Labor
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Henry Trupp

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Mary Wjellmin

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 2-25 1916 G G Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1916, to Feb 24 1916, that I last saw him alive on Feb 23 1916, and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
Septicemia
.....
.....
(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Peritonsilar Abcess
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) A Morehead M. D.
Feb 25 1916 (Address) St Charles

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho — DATE OF BURIAL: 2/26/1916

20. UNDERTAKER: Yeager — ADDRESS: St Charles

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 13544
Registered No. 12
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Alta Suby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 29 (Day) 1899 (Year)

7. AGE: 16 yrs. 10 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rigby Idaho

10. NAME OF FATHER: Adam Suby

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ramona Atkinson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emily Atkinson
(Address) Rigby

15. Filed 3-6 1916 G. L. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-2 1916, to 3-4 1916 that I last saw her alive on 3-4 1916 and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Meningitis

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. L. Espe M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: 3-7 1916

20. UNDERTAKER: Rigby — ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 13545
Registered No. 13
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosina Bieri

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Dec. (Month) 25 (Day) 1843 (Year)

7. AGE: 73 yrs. 2 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Jacob Widmer

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Elizabeth Bieri

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Gottlieb Bieri
(Address): Rexburg

15. Filed 3-8- 1916
Gly E Sp
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar. 6, 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Mar 3, 1916, to ..... 191..., that I last saw her alive on Mar 3, 1916, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:
From description of symptoms death seemed to be due to bulbar apoplexy. I did not see patient recently before death.
(Duration) ..... yrs. ..... mos. Sudden ds.
Contributory (Secondary): Arteriosclerosis. Left Hemiplegia
(Duration) [redacted] yrs. ..... mos. ..... ds.

(Signed) M Merriemon M. D.
Mar. 7 1916 (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg
DATE OF BURIAL: 3/9 1916

20. UNDERTAKER: John Phillips
ADDRESS: Rexburg

SYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee.
City of Silver
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 43
Primary Registration District No. 2120
(No. ....., ... St.)

File No. 13546
Registered No. 30
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Sprowles.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male.	White	Single

6. DATE OF BIRTH
Unknown. (Month) ..... (Day) 1856. (Year)

7. AGE
60 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canada.

10. NAME OF FATHER Unknown.

11. BIRTHPLACE OF FATHER (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (State or Country) Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. D. Berry
(Address) Silver City, Idaho.

15.
Filed Feby 8, 1916 W. N. Schuyler M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
February, 7, 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby. 2, 1916, to Feby. 6, 1916, that I last saw him alive on February 6, 1916, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Intussusception, Acute, with acute peritonitis.

(Duration) — yrs. — mos. 7 ds.
Contributory (Secondary) Epidemic Influenza
(Duration) — yrs. — mos. 2 1 ds.

(Signed) W. N. Schuyler M. D.
Feby 8. 1916 (Address) Silver City. Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
A. O. P. & E. Eagle Cemetary	Feb 9th 1916
20. UNDERTAKER	ADDRESS
John Prete.	Silver City Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5 13547

Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood

Registration District No. 105
Primary Registration District No. 2183
(No. Cottonwood 3 miles East.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Huff. Mary Jane Huff

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb. (Month) 18 (Day) 1916 (Year)

7. AGE: ....yrs. ....mos. ....ds.
IF LESS than 1 day how many 3 hrs. or ....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cottonwood Ida.

10. NAME OF FATHER: Lawrence Huff.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Ruth B. Harris

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lawrence E. Huff.
(Address) Cottonwood, Ida.

15.
Filed Feby 19th 1916 H Bowers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18 7 P.M. 1916, to Feb. 18 9 P.M. 1916
that I last saw her alive on Feb 18 1916
and that death occurred on the date stated above, at 9:50 A.M.

The CAUSE OF DEATH* was as follows: Premature birth, about seven months gestation

(Duration) ....yrs. ....mos. ....ds.

Contributory (Secondary): Unknown

(Duration) ....yrs. ....mos. ....ds.

(Signed) Stanley F. Orr M. D.
Feb. 19 1916 (Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....ds.
In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cottonwood
DATE OF BURIAL: Feb. 20 1916

20. UNDERTAKER: A. J Mugg
ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho

City of Ferdinand

Registration District No. 105

Primary Registration District No. 2183

(No. ....., ... St.)

File No. 4 13548

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Paul Fisher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 9th (Day) 1916 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many 8 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Lionel E. Fisher

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Florence B. Armstrong

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lionel Earl Fisher

(Address) Ferdinand Idaho.

15. Filed Feby 10 1916

H B Burke
Local Registrar

SYMS - YORK CO., PTRS. & ROBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 10th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9 1916, to Feb 10 1916, that I last saw him alive on Feb 10 1916, and that death occured on the date stated above, at 7. A. M.

The CAUSE OF DEATH* was as follows:

Probably Premature
Birth about 8 mon

(Duration) 0 Yrs. 8 mos. 8 hrs ds.

Contributory (Secondary): unknown

0 (Duration 0 yrs. 0 mos. 0 ds.

(Signed) Russell Truitt M. D.

Feb 10 1916 (Address) Ferdinand Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood

DATE OF BURIAL: Feb. 11 1916

20. UNDERTAKER: L J. Maugg

ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.7-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13549

Registered No. 34

1. PLACE OF DEATH.

Registration District No. 12

Primary Registration District No. 2-8-19

County of Boise

City of

(No. 12 East of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Franklin Gettys

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb 24 1852 (Month) (Day) (Year)

7. AGE: 63 yrs. 11 mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Elkhart. Ind.

10. NAME OF FATHER: Wm Gettys

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Sarah E. Davies

13. BIRTHPLACE OF MOTHER (State or Country): Ohio,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Grant Gettys.
(Address)

15.
Filed March 18 1916 May Fitz Deputy.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 13 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1916 to Feb 13 1916 that I last saw h im alive on 191 , and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Heart Disease accompanied with Dropsy

(Duration) yrs. mos. ds.

Contributory (Secondary) Acute Indigestion

(Duration) yrs. mos. ds.

(Signed) L. M. Babcock M. D.

2-18 1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: on the farm.

DATE OF BURIAL: 2/15 1916

20. UNDERTAKER: Schreiber & Siedenfaden

ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13551
Registered No. 99

1. PLACE OF DEATH.
County of Boise
City of Horseshoe Bend
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 2019
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH
Oct (Month) 28 (Day) 1828 ~~1826~~ (Year)

7. AGE
84 yrs. 4 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Blacksmith & wagon maker.
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Tenn.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Addie Smith
(Address) Horseshoe Bend

15.
Filed March 10 1916 May Fitz Deputy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from never attended 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Inflamation of Stomach & bowels.

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. D. Monot M. D.
1916 (Address) Do not know.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Horseshoe Bend
DATE OF BURIAL: March 1 1916

20. UNDERTAKER: Had none.
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Paris Ida.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2153
Primary Registration District No. 2132
(No. Annie Elizabeth St.)

File No. 13552
Registered No. 37
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ann Smith Hughes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	W.	Single

6. DATE OF BIRTH Dec 28 1844
Feb. 14 1916
(Month) (Day) (Year)

7. AGE 71 yrs. 1 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio.

10. NAME OF FATHER John Smith

11. BIRTHPLACE OF FATHER (State or Country) U. S.

12. MAIDEN NAME OF MOTHER Annie Elizabeth Smith

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Hughes
(Address) Paris Idaho

15.
Filed 3-10- 1916 J. Fullmer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 14 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1915, to Feb 14 1916, that I last saw her alive on Feb. 13 1916 and that death occurred on the date stated above, at 9:10 A.M.

The CAUSE OF DEATH* was as follows:
Mitral regurgitation
Valvular heart disease

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Rogers M. D.
2/16 1916 (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Paris Ida	Feb 16 1916

20. UNDERTAKER	ADDRESS
Bishop Poulson	Paris

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

CERTIFICATE OF DEATH

Registration District No. 122

Primary Registration District No. 220

(No. Mael St.) City of Mael Idaho

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13553

Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorsey S Blaisdell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 23 (Day) 1916 (Year)

7. AGE: 50 Yrs. ..... Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Steam filler
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Paris Kty. Marion Co

10. NAME OF FATHER H R Blaisdell

11. BIRTHPLACE OF FATHER (State or Country) Unknone

12. MAIDEN NAME OF MOTHER Unknone

13. BIRTHPLACE OF MOTHER (State or Country) Unknone

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs L Bleatley
(Address) Black Bear Ida

15. Filed 2/25 1916 W C Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 23 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw b. alive on ..... 191...,
and that death occured on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:
Crushed & run over by the W. P. Ore Wagon
(Duration) ..... Yrs. Instant ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Chas R. Mowry Coroner
2/24 1916 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: 2/28 1916

20. UNDERTAKER: Wallace Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 2200
File No. 13554
Registered No. 2

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Tamarack Mine St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matt Dragonia (Haystack)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 38 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): austria

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): austria

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. E. Ward
(Address) Wallace Ida

15. Filed 2/25 1916 W. S. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 20 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h[illegible] alive on Feb 20 1916,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Pyaemia Secondary to Gas Gangrene at [redacted] Tamarack Mine

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Chas R Mowery M.D.
2/23 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Tamarack Mine

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Feb 23 1916

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24853

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13555
Registered No. 3

1. PLACE OF DEATH.
County of Lewis
City of Nezperce
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 47
Primary Registration District No. 2124
(No. ....., ... St.)

2. FULL NAME Wm B. Fisher

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept 3 1848 (Month) (Day) (Year)

7. AGE: 67 yrs. 5 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Adam Fisher

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. B. Fisher
(Address) Pony, Montana

15.
Filed 2-28 1916 J. P. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 28 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1916, to Feb 28 1916 that I last saw h[illegible] alive on Feb 27 1916 and that death occurred on the date stated above, at 12:15 M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach and Liver

..... (Duration) ..... yrs. 6 mos. 5 ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Jones M. D.
2-28 1916 (Address) Nezperce, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pony, Montana
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: P. E. Miller
ADDRESS: Nezperce Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 13557
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel Richardson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Feb (Month) 8 (Day) 1889 (Year)

7. AGE: 27 Yrs. 0 Mos. 22 ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Printer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kentucky

10. NAME OF FATHER S D Richardson

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Susan H Richardson

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ella F Richardson
(Address) Nampa Ida

15. Filed Mar 3 1916 Dr D Calonge Local Registrar
Emma Canfield Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ ..... 191....., to ..... 191....., ~~that I last saw h~~ alive on ..... 191....., ~~and that death occured~~ on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows: Murder from guns shot wounds from the hands of Ernest Hardenburg. Self Confessed.

(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

(Duration .....yrs. .....mos. .....ds.

(Signed) A A Faris Canyon Co. Coroner M. D.

19..... (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 3-5 1916

20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa Ida

SYMS - YORK CO., PTRS. & STNRS. 2/5/16

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 13558
Registered No. ____

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Hepzabah Drummond
If death occurred in a hospital, institution or camp, give NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Jan. (Month) 18 (Day) 1848 (Year)

7. AGE: 68 Yrs. 0 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ....
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9. BIRTHPLACE (State or Country): London Eng.

10. NAME OF FATHER: Francis Boot

11. BIRTHPLACE OF FATHER (State or Country): London Eng.

12. MAIDEN NAME OF MOTHER: Elizabeth Hepzabah Boot

13. BIRTHPLACE OF MOTHER (State or Country): London Eng

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arthur Drummond
(Address) Nampa, Idaho

15. Filed Feb 8, 1916 D R D Colony (Local Registrar)
Nampa Leader-Democrat Co. Print. Boise 13558

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3d (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23rd 1914, to Feby 3rd 1916, that I last saw her alive on Feby 3rd 1916, and that death occured on the date stated above, at 9.30 P.M.

The CAUSE OF DEATH* was as follows:
Paralysis
(Duration) 1 Yrs. 9 mos. ds.
Contributory (Secondary) ....
(Duration ... yrs. ... mos. ... ds.

(Signed) J H Murray M. D.
Feb 4 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death? ....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Boise Ida — DATE OF BURIAL ... 191...

20. UNDERTAKER: J. L. Robertson — ADDRESS Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V[redacted]. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 13559
Registered No. ____

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert A Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Jan (Month) 2 (Day) 1849 (Year)

7. AGE
67 Yrs. 1 Mos. 25 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE
(State or Country) Ohio

10. NAME OF FATHER: Samuel Johnson

11. BIRTHPLACE OF FATHER
(State or Country) Don't Know

12. MAIDEN NAME OF MOTHER: Elizabeth Gaines

13. BIRTHPLACE OF MOTHER
(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. A. Johnson
(Address) ____

15.
Filed Feb 28 1916 W S Calouge Local Registrar
By Nina Hatfield Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 27- 10 AM 1916, to ____ 191__, that I last saw him alive on Feb 27 at 1:30 AM 1916, and that death occured on the date stated above, at 4 PM.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) Clyde Watson M. D.
Feb 28 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs ____ mos ____ days. In the State ____ yrs ____ mos ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Rosedale Cem
DATE OF BURIAL: 2/29 1916

20. UNDERTAKER: F K Robinson
ADDRESS: Nampa Ida

SYMS - YORK CO., INC. SERIES 2803

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 13560
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward T Larson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	Married

6. DATE OF BIRTH.
Feby (Month) 4 (Day) 1875 (Year)

7. AGE
41 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Banker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Wis

10. NAME OF FATHER
Lewis Larson

11. BIRTHPLACE OF FATHER
(State or Country) Norway

12. MAIDEN NAME OF MOTHER
Margaret Joyce

13. BIRTHPLACE OF MOTHER
(State or Country) Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anita E. Larson
(Address) .....

15.
Filed Mar 7 1916 Dell Colvocoresses Local Registrar
Emma Fairfield Deputy.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 24 1916, to Mar 4 1916, that I last saw him alive on Mar 4 1916, and that death occured on the date stated above, at 9.50 P.M.

The CAUSE OF DEATH* was as follows:
Gunshot Wound of Thorax and Abdomen - Accidental

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Murray M. D.
Mar 6 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn Cem	3-7 1916

20. UNDERTAKER	ADDRESS
F. K. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAMP - YORK CO., PTRS. & BOOKBDRS.

(Always write with black ink)

TRANSPORTATION OF CORPSE

1. PLACE OF DEATH.

County of Bonneville

City of Ferrill

CERTIFICATE OF DEATH.

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

STATE OF IDAHO
BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
File No. 13561
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Marie Roepcke

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed or Divorced. (Write the Word)
Female	White	Widowed

6. DATE OF BIRTH. December 1 1871
(Month) (Day) (Year)

7. AGE. 44 Yrs. 2 Mos. 14 ds.
IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION.
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE.
(State or Country) California

10. NAME OF FATHER Charles C Tautphaus

11. BIRTHPLACE OF FATHER
(State or Country) New York

12. MAIDEN NAME OF MOTHER Sarah J. Kane

13. BIRTHPLACE OF MOTHER
(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs K. T. Johnston
(Address) Idaho Falls Idaho

15. Filed 2-15 1916 W L Mackaby
Local Registrar.

Place Where Remains are to be Sent.	Date of Shipment
Idaho Falls Idaho.	2-15 1916

SHIPPING UNDERTAKER
ADDRESS W L Mackaby Firm Name W. Mann.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 14 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1916, to Feb 14 1916; that I last saw h[illegible] alive on Feb 14 1916, and that death occurred on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH was as follows:
La Grippe + Pneumonia

.....(Duration) .....Years .....mos. 8 ds.

Contributory (Secondary) .....

.....(Duration) .....Years .....mos. .....ds.

(Signed) H N Leeds M. D.
Feb 15 1916 (Address) Idaho Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Sucidial or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)
At place of death .....yrs. .....mos. .....days
In the State .....yrs. .....mos. .....days

Where was disease contracted if not at place of death .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	Date of Burial
Idaho Falls Idaho	.....191....

20. UNDERTAKER	Address
W L Mackaby	W. Mann

The information on this certificate is an exact COPY of the official certificate filed at place of death.

Party in charge of Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2135
File No. 13562
Registered No. 838

1. PLACE OF DEATH.
County of Bonner
City of Clark Fork
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME R. H. Eckley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	White	Married

6. DATE OF BIRTH Unknown (Month) Feb (Day) X (Year) 1916

7. AGE Abt. 60 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J R Derr
(Address) Clark Fork Ida

15. Filed Feb 2 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Paralysis of the Heart

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Tuberculosis
..... (Duration) ..... yrs. 6 mos. or more ds.

(Signed) W. M. Knapp M. D.
19.... (Address) Hope, Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? Nebraska
Former ~~or usual~~ residence ..... Nebraska

19. PLACE OF BURIAL OR REMOVAL: Clark Fork
DATE OF BURIAL: Feb 3rd 1916

20. UNDERTAKER E. M. Brower
ADDRESS Sand Point Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2135

File No. 13563

Registered No. 859

County of Bonner

City of Hope (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Albaugh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: July (Month) 11 (Day) 1837 (Year)

7. AGE: 78 yrs. 6 mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: R. R. Engineer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Adam Albaugh

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: — Stein

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Feb 7 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2nd 1916, to Feb 6 1916, that I last saw him alive on the 6th of Feb 1916, and that death occurred on the date stated above, at 6.40 P.M.

The CAUSE OF DEATH* was as follows:

Cebral Hemmorhage
Complete Paralysis
Second Stroke - 1st Stroke (Duration) about 6 yrs. ago mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W M Knapp M. D.

19.... (Address) Hope Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Hope

DATE OF BURIAL: Feb 9 1916

20. UNDERTAKER: E M Bower

ADDRESS: Sandpoint

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Jackson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2155

File No. 13564

County of Bonner

City of Sandpoint (No. ....., ... St.)

Registered No. 860

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Morris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE 67 yrs. 2 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... laborer

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jessie Leichgow

(Address) Sandpoint

15. Filed Feb 8 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 6 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1-3 1915, to Febry 6 1916, that I last saw him alive on Febry 6 1916, and that death occurred on the date stated above, at 1 a. M.

The CAUSE OF DEATH* was as follows:

Cirhosis of Liver -

..... (Duration) Unknown yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R O Jackson M. D.

19 ..... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint	Feb 26 1916
20. UNDERTAKER	**ADDRESS**
E M Brower	L. D.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2185
File No. 13565
Registered No. 862

1. PLACE OF DEATH.
County of Bonner
City of Sand Point (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Bode

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH: Nov. (Month) 13 (Day) 1854 (Year)

7. AGE: 61 yrs. 2 mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business, or dstablishment in which employed (or employer): Retail

9. BIRTHPLACE (State or Country): County of Ruedesheim Schleswig-Holstein Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. D. G. Hardy
(Address) 402 First Ave E.

15. Filed Feb 12 1916 M. McKinney Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1916, to Feb 10 1916, that I last saw him alive on Feb 10 1916, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute Nephritis

(Duration) 8 yrs. ..... mos. ..... ds.

(Signed) Co. P. Strackbein M. D.
2/17 1916 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Butte Montana — DATE OF BURIAL: 2/13 1916

20. UNDERTAKER: E. M. Brown — ADDRESS: Sandpoint

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2155

File No. 13566

County of Bonner

City of Sandpoint (No. 328, S. First St.)

Registered No. 863

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Cairnes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: April (Month) 18th (Day) 1877 (Year)

7. AGE: 39 yrs. 9 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mechanic
(b) General nature of industry business, or dstablishment in which employed (or employer): Lumber Mill

9. BIRTHPLACE (State or Country): New Brunswick, Canada

10. NAME OF FATHER: William Cairnes

11. BIRTHPLACE OF FATHER (State or Country): New Brunswick, Canada

12. MAIDEN NAME OF MOTHER: Violet Gleorn

13. BIRTHPLACE OF MOTHER (State or Country): New Brunswick, Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Maud Ames
(Address) Sandpoint, Ida.

15.
Filed Feb 14 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1- 1915, to Feb 13 1916, that I last saw h[illegible] alive on Feb 13 1916, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.

Feb 14 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Idaho	2/15 1916
20. UNDERTAKER	ADDRESS
E M Brower	S P

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78 M 11

County of Bonner

Primary Registration District No. 2133

File No. 13567

City of Sandpoint (No. ....., ... St.)

Registered No. 864

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Norris William Brundage

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 24 (Day) 1855 (Year)

7. AGE: 60 yrs. 8 mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: R. R. Employ
(b) General nature of industry business, or dstablishment in which employed (or employer): Engineer

9. BIRTHPLACE (State or Country): New Brunswick Can.

10. NAME OF FATHER: Wm. Brundage

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ida A. Brundage
(Address) .....

15.
Filed Feb 15 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Febr (Month) 14 (Day) th 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1915, to Feb 11 1916, that I last saw h.m alive on Feb 11 1916, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrage due to Vomiting from Carcinoma of Stomach

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Ulcer of Stomach

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.

Feb 15 1916 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida. DATE OF BURIAL: 2/16 1916

20. UNDERTAKER: E M Prosser ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78 Shoshone Co.

Primary Registration District No. 2155

File No. 13568

County of Bonner

City of Sandpoint (No. ....., ... St.)

Registered No. 823

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edd Hill.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH

..... 1
(Month) (Day) (Year)

7. AGE

43 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Laborer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E M Brower

(Address) Sandpoint

15.

Filed Jan 17 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 15 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1915, to Jan 15 1916, that I last saw him alive on Jan 15 1916, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia

..... (Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Sage M. D.

19.... (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Idaho	Jan 20 1916

20. UNDERTAKER	ADDRESS
E M Brower	S P

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 215-5
File No. 13569
Registered No. 866

1. PLACE OF DEATH.

County of Bonner
City of 2 miles west of and East of Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rupert Hayes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) (Day) 1905 (Year)

7. AGE: 11 Yrs. 8 Mos. ds.

IF LESS than 1 day how many hrs. or min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: School People
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spokane Wash

10. NAME OF FATHER: Harry C Hayes

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Freda Newman

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H L Hayes
(Address) 808 Augusta

15. Filed Feb 24 1916 Mamie Lund Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1916 to 191, that I last saw h alive on 191, and that death occured on the date stated above, at 11-40 A M.

The CAUSE OF DEATH* was as follows:
Organic Disease of Heart Pulmonary Congestion
Feb 24 (Duration) 7 Yrs. mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) Wm Rowland M. D.
19 (Address) Coeur d'Alene Hospital

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 3 mos. days In the State 1 yrs. 3 mos. days
Where was disease contracted if not at place of death?
Former or usual residence at Place of Death

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL 1916

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2155

File No. 13570

City of Sandpoint (No. ....., ... St.)

Registered No. 867

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Simon Stiff

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH

..... 1
(Month) (Day) (Year)

7. AGE

28 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Laborer

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Finland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) Finland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A H Brayman

(Address) S P

15.

Filed Feb 25 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 24 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1916, to Feb 24 1916, that I last saw him alive on Feb 24 1916, and that death occurred on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Colon

..... (Duration) 1 yrs. 2 mos. 2 ds.

Contributory (Secondary) -

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E F Payne M. D.

19 ..... (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint	Feb 26 1916

20. UNDERTAKER	ADDRESS
E M Brownell	S P

CLAIMS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2155
File No. 13571
Registered No. 8 & 8

1. PLACE OF DEATH.
County of Bonner
City of Sand Point (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Bjorkquist
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	widowed

6. DATE OF BIRTH
October 10th 1843
(Month) (Day) (Year)

7. AGE
72 yrs. 4 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer, retired
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jena Adams
(Address) .....

15. Feb 28
Filed Mar 1 1916 W M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb 26 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1916, to Feb 26 1916, that I last saw h. alive on Feb 26 1916, and that death occurred on the date stated above, at 1130 a.m.

The CAUSE OF DEATH* was as follows:
Ruptured Hemorrhage, Cerebral

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Blackburn M. D.
3/7 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt Sandpoint	Mar 2 1916

20. UNDERTAKER	ADDRESS
C M Brower	S P

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Jackson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2155

File No. 13572

County of Bonner

City of Sandpoint (No. ....., ... St.)

Registered No. 869

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sweney Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 27 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jennie Hagan
(Address) 414 5th Ave

15.
Filed Mar 1 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb 27 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1915, to Feb 27 1916, that I last saw h..... alive on Feb 27 1916 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Pr Thesis.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C F Jagow M. D.

19.... (Address) Sandpoint.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Cemetery	Mar 3 1916

20. UNDERTAKER	ADDRESS
E M Bronner	L. & P.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13575
Registered No. 327

1. PLACE OF DEATH. Registration District No. 78
County of Bonner Primary Registration District No. 2135
City of Clarkfork (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilmefred Elinor Latham

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Jan. (Month) 31 (Day) 1916 (Year)
7. AGE: ____ yrs. ____ mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Clarkfork Idaho
10. NAME OF FATHER: W. F. Latham
11. BIRTHPLACE OF FATHER (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Cora Gertrude Brown
13. BIRTHPLACE OF MOTHER (State or Country): Illinois
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W W Kinnaird
(Address) Hope
15. Filed Feb 8 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 7th (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1916., to Feb 7 1916. that I last saw h[illegible] alive on Feb 7th 1916., and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:
Pre disposing premature birth
Convulsions
..... (Duration) ..... yrs. ..... mos. 7 ds.
Contributory (Secondary) Premature birth
..... (Duration) ..... yrs. ..... mos. 7 ds.
(Signed) E W Kinnaird M. D.
..... 19..... (Address) Hope

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clarkfork — DATE OF BURIAL: Feb 8 1916
20. UNDERTAKER: None — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 13576
Registered No. 16

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orel James Sessions

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH.
June (Month) 20 (Day) 1914 (Year)

7. AGE
— Yrs. — Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Apprentice
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jas M Sessions

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Lady Sessions

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jas M Sessions
(Address) Idaho Falls

15.
Filed Feb 17 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Tuberculosis
No medical attendance
.....
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
Feb 17 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sunset Mem — DATE OF BURIAL: Feb 19 1916

20. UNDERTAKER: [illegible] — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13577
Registered No. 22

1. PLACE OF DEATH. Registration District No. 73
County of Bonneville Primary Registration District No. 210
City of Ammon (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jonda Purcell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Child

6. DATE OF BIRTH: Aug. (Month) 18 (Day) 1915 (Year)

7. AGE: 0 yrs. 5 mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ammon, Ida

10. NAME OF FATHER E. L. Purcell

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Elmira Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. L. Purcell
(Address) Ammon RD 3 - Cty

15. Filed Feb 29 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1915 191.., to Feb 14, 1916 191.., that I last saw her alive on Feb 14, 1916 191.., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

catarrhal Pneumonia

..... (Duration) ..... yrs. ..... mos. 3 ..... ds.

Contributory (Secondary) Hydrocephalus, Spinal Meningocoele

..... (Duration) Always mos. ..... ds.

(Signed) [signature] M. D.

Feb 19 16 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ammon, Ida — DATE OF BURIAL: 2/16 1916

20. UNDERTAKER: C. C. Linwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13578

Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City or Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 21 D

(No. ..... St.)

2. FULL NAME Valentine Coughlin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): —

6. DATE OF BIRTH. Feb (Month) 11 (Day) 1916 (Year)

7. AGE: ..... Yrs. ..... Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho Falls Ida

10. NAME OF FATHER: Leo J. Coughlin

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Lulu Clark

13. BIRTHPLACE OF MOTHER (State or Country): Idaho, Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... O. Jensen

(Address) Idaho Falls Idaho

15. Filed Feb 19 1916 O. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1916, to Jan 19 1916, that I last saw her alive on Jan 19 1916, and that death occured on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Premature birth - Atel
7 - 8 months

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Feb 19 1916 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Idaho — DATE OF BURIAL: Feb 1916

20. UNDERTAKER: C J Simmonds — ADDRESS: Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & STRS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13579
Registered No. 14

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2130
(No. ..... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Claudius J. Fullmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE
39 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Farming
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER A. L. Fullmer

11. BIRTHPLACE OF FATHER (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Jane Griffith

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. L. Fullmer
(Address) .....

15. Filed Feb 21 1916 Carl Summond
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feby (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1916 to Feb 20 1916
that I last saw h-im alive on Feb 20 1916
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Acute Appendecitis

..... (Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Clive M. D.
Feb 20 1916 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence ..... Shipment

19. PLACE OF BURIAL OR REMOVAL: Petoria Ida
DATE OF BURIAL: 2/22 1916

20. UNDERTAKER: C. E. Dunwoody
ADDRESS: Ida Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2107
(No. ..... St.)

File No. 13580
Registered No. 19

1. PLACE OF DEATH.
County of Bannock
City of Ida Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME M. M. Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. ? (Month) (Day) 1 (Year)
7. AGE: 57 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Utah
10. NAME OF FATHER: Nels Peterson
11. BIRTHPLACE OF FATHER (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (State or Country): ?
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. M. Jorgensen
(Address) Ft. Hall, Idaho X
15. Filed Feb 26 1916 C. E. Dunwoody Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 25 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Took suddenly sick with
Stroke of Apoplexy
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. E. Dunwoody M. D.
Feb 26 1916 (Address) Ida Falls Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cache Idaho — DATE OF BURIAL: 2/26 1916
20. UNDERTAKER: C. E. Dunwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13581
Registered No. 20

Registration District No. 73
Primary Registration District No. 2107
(No. Gen. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls

2. FULL NAME Effie R Jeffery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 46 Yrs. 6 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Neb

10. NAME OF FATHER: Wm Reed

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: M. A. Snar

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C C Dunwoody
(Address) Ida Falls

15. Filed Sep 29 1916 Geo Fuhrman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/22 1916, to 2/25 1916, that I last saw her alive on 2/25 1916, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Septic Cholecystitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. C. Hollister, M. D.

2/ 1916 (Address) Ida Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Sweden Cemetery — DATE OF BURIAL: 2/29 1916

20. UNDERTAKER: C C Dunwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNUM - YORK CO., PTRS. & BDRS. 24653

Hollister

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13582

Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2107

(No. ....., ... St.)

2. FULL NAME Lillian T M Meppen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. March 13 1909 (Month) (Day) (Year)

7. AGE: 6 Yrs. 11 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: E. S. Meppen

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Delia L Ottmann

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. S. Meppen

(Address) City

15. Filed Feb 25 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby 21 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1916, to February 21, 1916, that I last saw her alive on 21 Feb., 1916, and that death occured on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Septic encephalitis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Purulent Otitis Media

(Duration Indefinite) ..... mos. ..... ds.

(Signed) John C. Millar M. D.

Feb 25 1916 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls, Ida — DATE OF BURIAL: 2/27/1916

20. UNDERTAKER: E. E. Dunwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 1 2
(No. ....., ... St.)

File No. 13583
Registered No. 12

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Verna Andrus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH.
Oct (Month) 31 (Day) 1915 (Year)

7. AGE
0 Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho Falls Idaho

10. NAME OF FATHER O. L. Andrus

11. BIRTHPLACE OF FATHER (State or Country) Dakota

12. MAIDEN NAME OF MOTHER Cora Jackson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. L. Andrus
(Address) Firth, Ida

15.
Filed Mar 7 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Whooping Cough
(Duration) 6 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Enteritis
(Duration) ..... yrs. ..... mos. ..... ds.
3/7 19 16 (Signed) C M Olsen M. D.
(Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Firth Idaho — DATE OF BURIAL: 3/7 1916

20. UNDERTAKER: E E Dinwoody — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

Clinic

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Ida Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13
Primary Registration District No. 21-54
(No. ....., ... St.)

File No. 13584
Registered No. 13

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph F Berry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
May (Month) 30 (Day) 1888 (Year)

7. AGE
27 yrs. 8 mos. X ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) North Carolina

10. NAME OF FATHER J B Berry

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Mary J Beach

13. BIRTHPLACE OF MOTHER (State or Country) North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A W Berry
(Address) Connelly Springs N. C.

15.
Filed Jul 14 191 6 E Lough
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Accidental - Thrown from Sleigh - Intoxicated
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C E Dinwoodey M.D.
1/14 1916 (Address) Ida Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Connelly Springs	191 6

20. UNDERTAKER	ADDRESS
C E Dinwoodey	Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13585

Registered No. 14

1. PLACE OF DEATH.

Registration District No. 13

Primary Registration District No. 210

County of Bonneville

City of Idaho Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Chapin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 3rd (Day) 1839 (Year)

7. AGE: 76 Yrs. 11 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Judge.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rochester N. Y.

10. NAME OF FATHER: Orlando Chapin

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Maria Dickinson.

13. BIRTHPLACE OF MOTHER (State or Country): Chicopee Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Clarence Chapin

15. Filed Feb 14 1916 E. E. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4 P.M. Feb 13 1916, to 4 P.M. Dec 13 1915, that I last saw him alive on Dec 13th 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Acute indigestion on Gastritis.

(Duration) From Dinner to 4 P.M. Yrs. mos. ds.

Contributory (Secondary) No Pulse at wrist when I was called

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H.W. Pendleton M. D.

2/ 19 16 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence: Water ave City

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery — DATE OF BURIAL: Feb 15 1916

20. UNDERTAKER: G. F. Hunt. — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2110
File No. 13586
Registered No. 11

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Jane Briggs.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Single
6. DATE OF BIRTH. March 22 1915 (Month) (Day) (Year)
7. AGE: 1 Yrs. 9 Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho.
10. NAME OF FATHER: F. J. Briggs.
11. BIRTHPLACE OF FATHER (State or Country): Idaho.
12. MAIDEN NAME OF MOTHER: Verma L. Cotton
13. BIRTHPLACE OF MOTHER (State or Country): Iowa.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. F. J. Briggs
(Address) Idaho Falls Ida.
15. Filed Feb 17 1916 Countersigned Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1916, to Jan 16 1916, that I last saw h[illegible] alive on Jan 16 1916, and that death occured on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Gastro-Enteritis.
(Duration) Yrs. mos. 10 ds.
Contributory (Secondary) Cardiac Failure
(Duration) Yrs. mos. 4 ds.
(Signed) C M Clive M. D.
Feb 1 1916 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Cem. DATE OF BURIAL: Jan 17 1916
20. UNDERTAKER: W. H. Lindsley ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. ..... St.)

File No. 13587
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Barnett Gibbons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 5 (Month) 11 (Day) 1915 (Year)

7. AGE — Yrs. 8 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Russel B Gibbons

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Della J Hancock

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Russell B Gibbons
(Address) Weiser Idaho

15. Filed 1-30 1916 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1916, to Jan 29 1916, that I last saw h[illegible] alive on Jan. 29 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Cerebritis

(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) probably Septicaemia

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. M. Wallenmeyer M. D.
1/29 1916 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Cemetery — DATE OF BURIAL: 1/30/16 191

20. UNDERTAKER: W. McBratney — ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser
(No. ....., ... St.)

Registration District No. 86
Primary Registration District No. 1010

File No. 13588
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rodecia Oakes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Nov (Month) 8 (Day) 1833 (Year)

7. AGE: 82 Yrs. 3 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ky.

10. NAME OF FATHER: John Sturgeon

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Sylvia Sizemore

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George Oakes
(Address) Weiser Idaho

15.
Filed 2-19 1916 W. P. Hamilton Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February (Month) 16th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1916, to Feb 16 1916, that I last saw her alive on Feb 14 1916 and that death occured on the date stated above, at 9 a.M.

The CAUSE OF DEATH* was as follows:
Senility with abscess of breast

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) —

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) James A Young M. D.
Feb 17 1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser, Ida — DATE OF BURIAL: Feb 17 1916

20. UNDERTAKER: Northam & McCown — ADDRESS: Weiser Ida

FORM V. S. No. 5-36 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 13590
(No. ..... St.)
Registered No. 8

1. PLACE OF DEATH.
County of Washington
City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Buck Corkadon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Feb (Month) 26 (Day) 1840 (Year)

7. AGE: 75 Yrs. 11 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: ——

11. BIRTHPLACE OF FATHER (State or Country): ——

12. MAIDEN NAME OF MOTHER: ——

13. BIRTHPLACE OF MOTHER (State or Country): ——

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J W Corkadon
(Address) Weiser Idaho

15. Filed 2-15- 1916 W. P. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 22 1915, to Feb. 13 1916, that I last saw him alive on Feb. 13 1916, and that death occured on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Senility
(Duration) 1 Yrs. — mos. — ds.
Contributory (Secondary) Acute Myocarditis
(Duration — yrs. 1 mos. 0 ds.

(Signed) Ernest O. Finney M. D.
2/14 1916 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: 2/15 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

...PTRS. & SONS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13591

Registered No. 10

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 1010

Primary Registration District No. 86

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 13 (Day) 1875 (Year)

7. AGE: 41 Yrs. 1 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Elidyr

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. T. Johnson

(Address) Goodrich

15. Filed 2-21 1916 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

..... (Month) ..... (Day) 191... (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-19- 1916, to 2-19 1916, that I last saw h.. alive on 2-19- 1916, and that death occured on the date stated above, at 0730 M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. 3 ds.

(Signed) Sammy E. Savant M. D.

2/21 1916. (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: 2/20 1916

20. UNDERTAKER: Northcutt & McCaw — ADDRESS: Weiser Ida

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRUS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lewis

City of Kos

Registration District No. 60

Primary Registration District No. 2/29

(No. ....., ... St.)

File No. 13592

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilbur Byers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. (Month) 1 (Day) 1915 (Year)

7. AGE: ....Yrs. 3 Mos. 10 ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... boy.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Vollmer, Idaho

10. NAME OF FATHER Henry Byers

11. BIRTHPLACE OF FATHER (State or Country) Princeton, Ind.

12. MAIDEN NAME OF MOTHER Lizzy McQueen

13. BIRTHPLACE OF MOTHER (State or Country) Palouse, Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Byers

(Address) Vollmer R.F.D.

15.

Filed 2/11 1916 P. E. Dunlap M. D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1915, to Feb 10 1916, that I last saw h[illegible] alive on Feb 10 1916, and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Incarcerated inguinal hernia of right side.

(Duration) ....Yrs. ....mos. 2 1/2 ds.

Contributory (Secondary) Hematuria

(Duration ....yrs. ....mos. 1 1/2 ds.

(Signed) P. E. Dunlap M. D.

Feb 11 1916 (Address) Kos, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I. O. O. F. Cemetery — DATE OF BURIAL: Feb 11 1916

20. UNDERTAKER: Stat Hdw & Undertaking — ADDRESS: Kos Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24858

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13593
Registered No. 2

1. PLACE OF DEATH.
County of Lewis
City of Winchester

Registration District No. 48
Primary Registration District No. 2127
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esly W Bear

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: April 30 (Month) (Day) 1853 (Year)

7. AGE: 64 yrs. 9 mos. 29 ds.
IF LESS than 1 day how many.....hrs. or .....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Union Rock Co Wisc

10. NAME OF FATHER: Edward F Bear

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Sarah Story

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W W Bear
(Address) Garfield, Wash.

15.
Filed 3-1- 1916 Elsie M. Rogers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 29 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16 1915, to Feb. 29. 1916
that I last saw him alive on Feb 29 1916
and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Hepatic Cirrhosis
Chronic Parenchymatous
Nephritis
(Duration) 4 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Elsie M. Rogers M. D.
3-1- 1916 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds.
In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ida. Idaho
DATE OF BURIAL: 3-2-1916

20. UNDERTAKER: H. R. Merchant
ADDRESS: Clarkston Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13594
Registered No. 15

1. PLACE OF DEATH.
Registration District No. 3
Primary Registration District No. 2005
County of Canyon
City of Caldwell Rural 4 (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dora R. Dempke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Jan. (Month) 22 (Day) 1868 (Year)

7. AGE 48 — 48 Yrs. ..... Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER Daniel Hershey

11. BIRTHPLACE OF FATHER (State or Country) Md.

12. MAIDEN NAME OF MOTHER Dont know

13. BIRTHPLACE OF MOTHER (State or Country) Md.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Russell H Garman
(Address) Garnet Idaho

15. Filed Feb 12 1916 — Jos. S. Dwyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 26 1916, to Feb. 11 1916, that I last saw h[illegible] alive on Feb. 10 1916, and that death occured on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:
Apoplexy -

(Duration) ..... Yrs. ..... mos. 15 ds.
Contributory (Secondary) Beat up by insane husband.
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jos. S. Dwyer M. D.
2/12 1916. (Address) Caldwell - Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilder — DATE OF BURIAL: Feb 13 1916

20. UNDERTAKER: W C Dyer — ADDRESS: Caldwell Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13595
Registered No. 16

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 2005
City of Caldwell (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James R. Fraser

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1873 (Year)

7. AGE: 53 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Engineer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nova Scotia

10. NAME OF FATHER: Peter Fraser

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: No information

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tom McClanahan
(Address) Payette

15.
Filed Feb. 15 1916 Jack P. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1916, to Feb 12 1916
that I last saw h[illegible] alive on Feb 12 1916,
and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Abscess of lung

..... (Duration) ..... yrs. 2 mos. ..... ds.
Contributory (Secondary) Lung trouble
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Forney M. D.
Feb 15 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: Feb. 15 1916

20. UNDERTAKER: Peckham Car Co. ADDRESS: Caldwell

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ....., ... St.)

File No. 13596
Registered No. 17

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jennie Colay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fema	White	Married

6. DATE OF BIRTH. Jan (Month) 13 (Day) 1840 (Year)

7. AGE 75 Yrs. 1 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Clark County, Kentucky

10. NAME OF FATHER Carlo Grimes

11. BIRTHPLACE OF FATHER (State or Country) Clark Co State of Kentucky

12. MAIDEN NAME OF MOTHER Louisa Talbott

13. BIRTHPLACE OF MOTHER (State or Country) Bourbon Co Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C.P. Grimes
(Address) Caldwell Idaho

15. Filed Feb. 15, 1916. John L. Meyer. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 13th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 6th 1915, to Feb. 13th 1916, that I last saw her alive on "13th 1916 and that death occured on the date stated above, at 11 a.m. M.

The CAUSE OF DEATH* was as follows:
Apoplexy.

(Duration) Yrs. 2 mos. ..... ds.
Contributory (Secondary) Lagrippe.
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John L. Meyer M. D.
2/13/1916 (Address) Caldwell Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Canyon Hill. DATE OF BURIAL 2-15-1916

20. UNDERTAKER W.C. Dyer. ADDRESS Caldwell Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13597

Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

County of Canyon

City of Caldwell R.2 (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Owen Hatfield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 27 (Day) 1839 (Year)

7. AGE: 76 Yrs. 8 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio.

10. NAME OF FATHER Wheatly Hatfield

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Rachel Harris

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Cynthia R. Hatfield
(Address) Caldwell, Idaho R.2.

15. Filed Feb. 15 — 1916 — Jos. S. Moyes, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1916, to Feb 14 1916, that I last saw h~~im~~ alive on Feb 12 1916, and that death occured on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Nephritis
Bronchial Asthma

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. J. Miller M. D.

2-15-16 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Dayton Oregon — DATE OF BURIAL: 2/15 1916

20. UNDERTAKER: W. E. Dye — ADDRESS: Caldwell.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13598

Registered No. 12

Registration District No. 8

Primary Registration District No. 2005

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bonnie Mynatt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fema.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. – 5 – 1880 (Month) (Day) (Year)

7. AGE: 36 Yrs. ..... Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER J. H. Mynatt

11. BIRTHPLACE OF FATHER (State or Country) Tennessee

12. MAIDEN NAME OF MOTHER Rose A. Baker

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Beatrice Mynatt

(Address) Caldwell, Ida.

15. Filed Feb. 16 1916

John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 15 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1916, to Feb. 15 1916, that I last saw h.. alive on Feb. 14 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Myxedema

practically all her life.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Gee M. D.

2/15 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Feb 16 1916

20. UNDERTAKER: W. C. Dyer — ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BORS. 24653

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 8

County of Canyon Primary Registration District No. 2005

City of Greenleaf (No. ....., ... St.)

File No. 13599

Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agnes Hebert

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Mar. (Month) 3" (Day) 1850 1916 (Year)

7. AGE: 66 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs.* or ..... *min.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Noel Hebert

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Marisa Hebert

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15.

Filed 3-6-1916 John V. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 3" (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 23" 1916, to Mar. 3" 1916, that I last saw h.. alive on Feb. 23" 1916, and that death occurred on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Brights Disease"

..... (Duration) 1 yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Hury M. D.

Mar. 4" 1916. (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 3/6 1916

20. UNDERTAKER: R. C. Dyer — ADDRESS: Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 13600
Registered No. 21

1. PLACE OF DEATH.
County of Canyon
City of Caldwell Rural.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth M Keedick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (write the word.): Widowed

6. DATE OF BIRTH. January 2 1835
(Month) (Day) (Year)

7. AGE: 81 Yrs. 2 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeping
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: David McKay

11. BIRTHPLACE OF FATHER (State or Country): Va

12. MAIDEN NAME OF MOTHER: Sarah Davey

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W E Keedick
(Address) Caldwell Ida

15. Filed March 8 1916
John L. Dreyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1 1916, to Mar. 6 1916, that I last saw her alive on Feb. 26 1916, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
La Grippe
(Duration) Yrs. 1 mos. ..... ds.
Contributory (Secondary) Pleurisy
(Duration) ..... yrs. 2 mos. 15 ds.

(Signed) C M Kaler M. D.
3-7 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Mt Vernon Iowa
DATE OF BURIAL: 3/8 1916

20. UNDERTAKER: W. E. Dyer
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.....
Primary Registration District No.....
(No. ....., ... St.)

File No. 13601
Registered No. 13

1. PLACE OF DEATH.
County of Gem
City of Sweet
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Weatherholt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Do not Know (Month) (Day) (Year)

7. AGE: about 65 yrs ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Do not Know

10. NAME OF FATHER: " " "

11. BIRTHPLACE OF FATHER (State or Country): " " "

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George W. Strion
(Address) Sweet, Idaho.

15. Filed Feb 13 1916 E Cadman Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: about Feb 8th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h.....alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Found dead in bed
Feb. 12-1916
Presumed died from Heart failure
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C D Bucknum M. D.
2/12 1916 (Address) Emmett Ida Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sweet Idaho
DATE OF BURIAL: 2/12 1916

20. UNDERTAKER: C D Bucknum
ADDRESS: Emmett Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cassia
City of Oakley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 170
Primary Registration District No. 8199
(No. ....., ... St.)

File No. 13602
Registered No. 4
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura Belle Borem

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec. 9 (Month) (Day) 87 (Year)

7. AGE: 38 yrs. — mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: David Walker

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Elizabeth Canning

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): E. P. Bohanan
(Address): Oakley Idaho

15. Filed Mch 10 1916 E. P. Bohanan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 13 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb - 3 1916, to Feb. 13 1916, that I last saw h[illegible] alive on Feb 11 1916, and that death occurred on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:
Gall stone
Cholemia.

(Duration) yrs. 6 mos. — ds.

Contributory (Secondary)
(Duration) — yrs. — mos. 10 ds.

(Signed) E. P. Bohanan M. D.
2/14 1916 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley
DATE OF BURIAL: 2-16 1916

20. UNDERTAKER: R. Harper
ADDRESS: Oakley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 57
Primary Registration District No. 2136
(No. ....., ... St.)

File No. 13603
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Abbie Irene Arnold

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female.	White	Single

6. DATE OF BIRTH: Feb. 7th 1916.
(Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ... hrs. or 30 mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montpelier

10. NAME OF FATHER: Alma Arnold.

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Abbie Coburn

13. BIRTHPLACE OF MOTHER (State or Country): Montpelier Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alma Arnold.
(Address) Montpelier Ida

15. Filed 2/7/ 1916 H. W. Hoffing Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 - 7 - 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2 - 5 1916, to 2 - 7 1916, that I last saw h.. alive on 2 - 5 1916, and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Bronchitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Cathey M. D.

2/7 1916 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier — DATE OF BURIAL: 2-9-1916

20. UNDERTAKER: Tarbell — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 13604
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Dingle (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Sorenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Sing Co

6. DATE OF BIRTH: Jan 19 (Month) (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: infant
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dingle

10. NAME OF FATHER: Andrew Sorenson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Sarah Jane Weaver

13. BIRTHPLACE OF MOTHER (State or Country): Bennington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr J H Lyons
(Address) Montpelier

15. Filed 3/1/1916 A N Kinsey Reg
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 26-16 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from on 26 Jan 1916, to ..... 1916, that I last saw her alive on 26 Jan 1916 and that death occurred on the date stated above, at ..... P M.

The CAUSE OF DEATH* was as follows: Unknown (Sneakling)

7 days (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr J H Lyons M. D.

1916 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? Dingle

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dingle | DATE OF BURIAL: Jan 26 1916

20. UNDERTAKER: The Nels[illegible] Co | ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181
(No. ....., ... St.)

File No. 13605
Registered No. 6
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louisa Thomas

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Widow

6. DATE OF BIRTH: Dec (Month) 29 (Day) 1841 (Year)

7. AGE: 74 yrs. 2 mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Miss

10. NAME OF FATHER: W. W. Cash

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Emily

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W W Cash
(Address) Grangeville Ida,

15. Filed March 6 1916 G B Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1916, to Feb 20 1916
that I last saw h.er alive on Feb 19 1916
and that death occurred on the date stated above, at 1. a. M.

The CAUSE OF DEATH* was as follows:

Chronic Bright's

(Duration) unknown yrs. mos. ds.
Contributory (Secondary) Valvular heart disease
(Duration) unknown yrs. mos. ds.

(Signed) G B Stockton M. D.
2/20 1916 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt Idaho	Feb 21 1916

20. UNDERTAKER	ADDRESS
W E Graham	Grangeville

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1001
Primary Registration District No. 103
File No. 13606
Registered No. 3

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Suzanne Garland

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: February (Month) 11 (Day) 1847 (Year)

7. AGE: 69 yrs. 0 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Nicholas Rummel

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Maria Hagen

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Estella Carroll
(Address) Grangeville Ida

15.
Filed March 6 1916 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 16 1916, to Feb 17 1916
that I last saw her alive on Feb 17 1916
and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) Acute dilatation and Brights disease
..... (Duration) 10 yrs. ..... mos. ..... ds.

(Signed) C W Slusser M. D.
Feb 17 1916 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: 2/19 1916

20. UNDERTAKER: W E Graham — ADDRESS: Grangeville

AYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2215
(No. ..... St.)

File No. 13608
Registered No. 8

1. PLACE OF DEATH.

County of Minidoka
City of Rupert

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helmuth Andrew Schmabel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 23 (Day) 1913 (Year)

7. AGE: Yrs. 3 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kiamma, Ida

10. NAME OF FATHER: H. H. Schmabel

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Katherine Meyer

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. H. Schmabel
(Address) Kiamma Ida.

15. Filed 2-23 1916 E. H. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 8 1915, to Dec. 27 1915, that I last saw h. alive on Dec. 27 1915, and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Enteritis - colitis

(Duration) ..... Yrs. ..... mos. 39 ds.

Contributory (Secondary) Malnutrition

(Duration ..... yrs. 9 mos. ..... ds.

(Signed) E. H. Elmore M. D.

2-23 1916 (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kiamma — DATE OF BURIAL: 1-16 1916

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert Ida.

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13611

Registered No. .....

1. PLACE OF DEATH.

County of Teton

City of Victor

(No. ....., ... St.)

Registration District No. 20

Primary Registration District No. 2012

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 14 (Day) 1897 (Year)

7. AGE: 18 Yrs. 8 Mos. 2 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... General Work
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kellogg Idaho

10. NAME OF FATHER Wm S Thompson

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Sarah L Thompson

13. BIRTHPLACE OF MOTHER (State or Country) Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Thompson
(Address) Victor Idaho

15. Filed Feb 16 1916 Geo D Charles Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-12 1916, to 2-16 1916, that I last saw h[illegible] alive on 2-15 1916, and that death occured on the date stated above, at .....M

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

.....(Duration) .....Yrs. .....mos. 6 ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) Dew K Hoagman M. D.

2-16 1916 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Victor Idaho

DATE OF BURIAL: 2-18 1916

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13613
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of Burley
(No. ..... St.)
Registration District No. 39
Primary Registration District No. 2087
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Leslie Eveleth
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: —

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Apr. (Month) 15 (Day) 1913 (Year)

7. AGE: 2 Yrs. 9 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Burley

10. NAME OF FATHER Geo. Eveleth

11. BIRTHPLACE OF FATHER (State or Country) Lewiston Maine

12. MAIDEN NAME OF MOTHER Stella McKay

13. BIRTHPLACE OF MOTHER (State or Country) Dellmore Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Stella L. Eveleth
(Address) Burley Idaho

15. Filed Feb 10 1916 J. T. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1915, to Feb 9 1916, that I last saw him alive on Feb 8 1916, and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Heart cause myocard itis —
(Duration) ..... Yrs. 2 mos. ..... ds.
Contributory (Secondary) Toxic Tonsilitis Hypertrophic
(Duration) ..... yrs. 4 mos. ..... ds.
(Signed) O. Tibbetts M. D.
2/9 1916 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley — DATE OF BURIAL: Feb 10 1916

20. UNDERTAKER: Homer B Evans — ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 13614
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of Burley
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hiram Baxter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 3 (Day) 1917 (Year)

7. AGE 94 Yrs. 9 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) N.M

10. NAME OF FATHER Hiram Baxter

11. BIRTHPLACE OF FATHER (State or Country) N.Y

12. MAIDEN NAME OF MOTHER Harriet Nead

13. BIRTHPLACE OF MOTHER (State or Country) N.Y

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. O. Kusher
(Address) .....

15. Filed 2-17 1916 J. F. Merrill Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h.. alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pneumonia -
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Senility
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Chas. Wechsler M. D.
19... (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Soc City Idaho — DATE OF BURIAL ..... 191...

20. UNDERTAKER: Homer B Evans — ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STAR - YORK CO., PTRS. & STRS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls. Registration District No. 39
City of Buhl. Primary Registration District No. 2087 (No. ....., ... St.) File No. 13615
Registered No. .....
If death occurs away from usual residence, give facts called for under special information. If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lawrence Warren Harrington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Sep. (Month) 13 Feb (Day) 1913 (Year)

7. AGE: 2 yrs. 4 mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: R. T. Harrington.

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Lota Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. T. Harrington
(Address) .....

15. Filed 2-10 1916. J. N. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 5 1916, to Feb. 10 1916, that I last saw him alive on Feb. 8 1916, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Tubercular Meningitis
(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Murphy M. D.
2-10 1916 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl Ida | DATE OF BURIAL: 2/12 1916

20. UNDERTAKER: Homer B. Evans | ADDRESS: Buhl

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13616

Registered No.

1. PLACE OF DEATH.

County of Twin Falls

City of Burke

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 39

Primary Registration District No. 2087

(No. , St.)

If death occured in hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara Charlotte Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 28 (Day) 1843 (Year)

7. AGE: 72 yrs. 4 mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden, Turnavella, Co.

10. NAME OF FATHER: Gustave Danielson

11. BIRTHPLACE OF FATHER (State or Country): Sweden, Turnavella,

12. MAIDEN NAME OF MOTHER: Mrs Danison

13. BIRTHPLACE OF MOTHER (State or Country): Sweden Turnavella.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. E. Erickson
(Address) Renton Wash.

15. Filed 2-28 1916 J. W. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 10 191 , to Feb. 26 1916 that I last saw her alive on Feb. 26 1916, and that death occurred on the date stated above, at 10:10 M.

The CAUSE OF DEATH* was as follows:
Enlargement of heart, Oedema, Albumen of urine

(Duration) 2-5 yrs. one mos. one ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) James Monroe M. D.
Feb. 26 1916 (Address) Burke, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Renton Wash. DATE OF BURIAL: 191

20. UNDERTAKER: N. B. Evans. ADDRESS: Burke Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 13617
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Burke
(No. ....., ..., St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Meineyer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. March (Month) 28 (Day) 1914 (Year)

7. AGE: 1 Yrs. 10 Mos. 24 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Burke Ida.

10. NAME OF FATHER G. J. Meineyer

11. BIRTHPLACE OF FATHER (State or Country) Holland

12. MAIDEN NAME OF MOTHER Margaret Smeker

13. BIRTHPLACE OF MOTHER (State or Country) Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. J. Meineyer
(Address) .....

15. Filed 2-22 1916
J. F. Murphy
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 19 1916, to Mar 21 1916, that I last saw h.. alive on Mar 21 1916, and that death occured on the date stated above at 6 M.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(Duration) 2 Yrs. mos. 6 ds.
Contributory (Secondary) Whooping cough
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Wellington M. D.
19..... (Address) Burke Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burke Ida. DATE OF BURIAL: 2-22 1916

20. UNDERTAKER: Homer B Evans ADDRESS: Burke Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2177
(No. .... St.)

File No. 13618
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Glenn Clarence Beeson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan (Month) 24 (Day) 1916 (Year)

7. AGE: 0 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Buhl

10. NAME OF FATHER Ray Beeson

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Lois Wilson

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S D Wilson
(Address) .....

15.
Filed 2-28 1916
J. A. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from One 1916 call only 1916,
that I last saw h.im alive on Feb 27 1916,
and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. Tibbetts M. D.

2/27 1916 (Address) Buhl Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl Idaho
DATE OF BURIAL: Feb 28 1916

20. UNDERTAKER: Homer B Evans
ADDRESS: Buhl

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Burke

Registration District No. 39
Primary Registration District No. 2087
(No. .... St.)

File No. 13619
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reva Alma Wasson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 16 (Day) 1915 (Year)

7. AGE ..... Yrs. 8 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Burke Idaho

10. NAME OF FATHER C. T. Wasson

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Clara Garwood

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. T. Wasson
(Address) .....

15. Filed 2-28 1916. J. H. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 27 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 20 1916, to Feb. 27 1916, that I last saw her alive on Feb. 27 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows: Pneumonia Broncho

.....(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Pertussis
.....(Duration ..... yrs. ..... mos. 14 ds.

(Signed) C. Thos. Welhaber M. D.
19..... (Address) Burke Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Burke Ida. DATE OF BURIAL Feb 29 1916

20. UNDERTAKER Homer B Evans ADDRESS Burke

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho

City of Kamiah

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 44

Primary Registration District No. 2128

(No. ....., ... St.)

File No. 13620

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Tezekiah Ezekiel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Oct. (Month) 4 (Day) 1901 (Year)

7. AGE: 14 yrs. 4 mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Chut of a child
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho county

10. NAME OF FATHER: Ezekiel

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) McCoy Hill
(Address) Kamiah Idaho

15. Filed 2/27 1916 W. T. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/24 1915, to 6/9 1915, that I last saw him alive on 11/23 1915, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Phthisis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. T. McMahan M. D.

2/27 1916 (Address) Kamiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind. Cem # 2 | DATE OF BURIAL: 2/29 1916

20. UNDERTAKER: C. J. Johnson | ADDRESS: Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Harrison, Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)

File No. 13621
Registered No. 6
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Child of J. W. Ramage

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH 5
April (Month) 6th (Day) 1915 (Year)

7. AGE
No yrs. 10 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Harrison, Idaho.

10. NAME OF FATHER Jesse Wm Ramage

11. BIRTHPLACE OF FATHER (State or Country) Oregon.

12. MAIDEN NAME OF MOTHER Bessie Leone Estes.

13. BIRTHPLACE OF MOTHER (State or Country) Oregon.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F.W.Didier, M.D.
(Address) Harrison, Idaho.

15. Filed March 7 1916 R.S.Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
February (Month) 11th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 11th 1916, to Feb. 11th 1916, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) F.W.Didier M. D.
Feby 12" 1916 (Address) Harrison, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Harrison	2-13 1916

20. UNDERTAKER	ADDRESS
Erwheeler	Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13622
Registered No. 9

1. PLACE OF DEATH.
County of Kootenai
City of Medimont

Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernie Vignor

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: October 11 1907 (Month) (Day) (Year)

7. AGE: 8 yrs. 4 mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Thmas Vignor

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Sofia Glad

13. BIRTHPLACE OF MOTHER (State or Country): Hungary

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. C. Vignor
(Address): Medimont Ida

15. Filed March 7 1916 R. S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby 22 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.... that I last saw h..... alive on ..... 191.... and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Drowning - Dr'd'nt See body until after death

..... (Duration) ✓ yrs. ✓ mos. ✓ ds.

Contributory (Secondary) ✓

✓ (Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) C. E. Worthington M. D.
2/13 1916 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Medimont
DATE OF BURIAL: Feb 14 1916

20. UNDERTAKER
ADDRESS: Medimont Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Medimont

Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)

File No. 13623
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dmael Aledman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: October 15-th (Month) (Day) 1905 (Year)

7. AGE: 10 yrs. 3 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Wm Aledman

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Minnie Hazard

13. BIRTHPLACE OF MOTHER (State or Country): New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. O. Moe
(Address) Medimont Idaho

15. Filed March 7 1916 R.S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Febry 17 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Drowning, about 9 am.
Found body about 8 PM

..... (Duration) ✓ yrs. ✓ mos. ✓ ds.
Contributory ✓
(Secondary)
✓ (Duration) ✓ yrs. ✓ mos. ✓ ds.
(Signed) C. E. Wentworth M. D.
..... 19..... (Address) Ross Park Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Medimont
DATE OF BURIAL: Feb 14th 1916

20. UNDERTAKER
ADDRESS: Medimont Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 124
Primary Registration District No. 2204
File No. 13625
Registered No. 5

1. PLACE OF DEATH.
County of Kootenai
City of Harrison (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alma Dixon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 9 (Day) 1837 (Year)

7. AGE: 78 Yrs. 7 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Simmion Wells

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O D Dixon
(Address) Harrison Ida.

15. Filed Feb 7 1916 R S Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1916, to Feb 2 1916, that I last saw her alive on Feb 2 1916, and that death occured on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia
Lobar - double,
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Myocarditis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Cunning M. D.
2-2 1916 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison Cemetry
DATE OF BURIAL: 2/7 1916

20. UNDERTAKER: Eaton Heller
ADDRESS: Harrison Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BKBS. 24052

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 13525---

Name Alma Dewey

Date of Death Febraary 2nd, 1916

Cause of Death Lobar Pneumonia, double.

Contributary Cause of death

(Sign here) J.M. Feeney M.D.

FORM No. 2. No. 5-15 M. 1-30-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 29
County of Blaine Primary Registration District No. 2139 File No. 45
City of Arco (No. ....., ... St.) Registered No. 13626

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nicholas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 21 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Arco, Idaho

10. NAME OF FATHER Alfred Nicholas

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Bessie Hilary

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. W. Nicholas
(Address) Arco, Idaho

15. Filed 2/2 1916 Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1916, to Feb 2 1916, that I last saw her alive on Feb 2 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

2/2 1916 (Signed) [illegible] M. D.
(Address) Arco, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arco, Idaho — DATE OF BURIAL: 2/4 1916

20. UNDERTAKER: A. W. Nicholas — ADDRESS: Arco, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Kendrick
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6 3
Primary Registration District No. 2143
(No. ....., ... St.)

File No. 13627
Registered No. 23
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amanda McCay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Widow

6. DATE OF BIRTH
May (Month) 19 (Day) 1856 (Year)

7. AGE
66 yrs. 6 mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Perry Blackson
(Address) Kendrick Ida

15.
Filed Feb 20 1916 J E Hoyt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1916 to Feb 19 1916, that I last saw her alive on Feb 18 1916 and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Pulmonary Edema

(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Chronic nephritis
(Duration) 5 yrs. — mos. — ds.

(Signed) J. E. Hoyt M. D.
Feb 19 1916 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wild Rose Cemetery
DATE OF BURIAL: 2 21 1916

20. UNDERTAKER: None
ADDRESS: —

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147
Primary Registration District No. 67
File No. 13628
Registered No. 27

1. PLACE OF DEATH.
County of Latah
City of Deary
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Monica Peterson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Divorced

6. DATE OF BIRTH: Aug. (Month) 1 (Day) 1885 (Year)

7. AGE: 30 yrs. 6 mos. 4 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Dressmaker
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Mikkel Peterson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Anne Foe

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl E Grannis
(Address) Deary

15. Filed 2-7 1916 W. E. Faust
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 31 1916, to Feb. 5 1916, that I last saw h.er alive on Feb. 5 1916 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Ptomaine Poisoning

(Duration) — yrs. — mos. 6 ds.

Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) W. E. Faust M. D.
2-7 1916 (Address) Deary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery — DATE OF BURIAL: 2-8 1916

20. UNDERTAKER: none — ADDRESS: —

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147
Primary Registration District No. 67
File No. 13629
Registered No. 28

1. PLACE OF DEATH
County of Latah
City of Avon
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Anderson
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed
6. DATE OF BIRTH: Nov. 21 1841 (Month) (Day) (Year)
7. AGE: 74 yrs. 2 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Denmark
10. NAME OF FATHER: Jens Anderson
11. BIRTHPLACE OF FATHER (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Don't know
13. BIRTHPLACE OF MOTHER (State or Country): Denmark
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Johnny Anderson
(Address) Avon
15. Filed 2-12 1916 P. C. Faust Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 9 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Rheumatism going to heart according to report
(Duration) — yrs. — mos. — ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Avon Cemetery | DATE OF BURIAL: 2-14 1916
20. UNDERTAKER: J. E. Pickerd | ADDRESS: Troy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13630
Registered No. .....

1. PLACE OF DEATH.
County of Gem
City of Emmett
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....

2. FULL NAME George Demasters

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Feb (Month) 19 (Day) 1853 (Year)

7. AGE: 62 Yrs. 10 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Livery man
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Gideon Demasters

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Mary Ann Neel

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. C. DeMasters
(Address) Emmett Idaho

15.
Filed Jan 7 1916
J. V. Reynolds Local Registrar

SVMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1913, to Jan 4 1916, that I last saw h... alive on Jan 4 1916, and that death occured on the date stated above, at 2 00 M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Shoulder Rt Side
.....
.....
.....(Duration) 3 Yrs. 6 mos. ..... ds.
Contributory (Secondary) Pulmonary tuberculosis
.....(Duration Two yrs. ..... mos. ..... ds.
(Signed) J. V. Reynolds M. D.
1/7 1916 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 1/6 1916
20. UNDERTAKER: C. D. Bucknum
ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13631
Registered No. .....

1. PLACE OF DEATH.
County of Elmore
City of Emmett
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 6
Primary Registration District No. .....
(No. ..... St.)

2. FULL NAME Elizabeth Irving

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. June (Month) 18 (Day) 1835 (Year)

7. AGE: 80 Yrs. 6 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: William McCleary

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Elizabeth McKenzie

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jessie L. Peterson
(Address) Boise Idaho

15. Filed 1-10-1916 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1916, to Jan 6 1916, that I last saw her alive on Jan 6 1916, and that death occured on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:
Uremia
.....
.....
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Arterio Sclerosis and Chronic nephritis
(Duration deceased) ..... mos. ..... ds.
(Signed) J. L. Reynolds M. D.
1-10 1916 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: Jan 8 1916

20. UNDERTAKER: C. A. Buckenum — ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13632
Registered No. .....

1. PLACE OF DEATH.
County of Gem
City of Emmett
(No. ....., 6 St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....

2. FULL NAME David G. Scott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Aug. (Month) 4 (Day) 1861 (Year)

7. AGE
64 Yrs. 5 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER William H. Scott

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Mary Short

13. BIRTHPLACE OF MOTHER (State or Country) Md.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Burton A. Scott
(Address) Powersville, Mo.

15.
Filed 1-21 1914
J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
1 (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1915, to Jan 19 1916, that I last saw him alive on Jan 19 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) 4 Yrs. mos. ds.
Contributory (Secondary) Arterio sclerosis and Cardiac insufficiency
(Duration yrs. mos. ds.
(Signed) J. L. Reynolds M. D.
1-21 1914 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Ida
DATE OF BURIAL: 1/22 1916
20. UNDERTAKER: O. Bucknum
ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No.
(No. ..... St.)

File No. 13633
Registered No. .....

1. PLACE OF DEATH.
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myrtle Baillie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 8 (Day) 897 (Year)

7. AGE: 18 Yrs. 1 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: G. W. Hickerson

11. BIRTHPLACE OF FATHER (State or Country): Do not Know

12. MAIDEN NAME OF MOTHER: Nettie Marshall

13. BIRTHPLACE OF MOTHER (State or Country): Do not Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs J. T. Athanas
(Address) Banks Ida

15.
Filed 1-19-1916
J. T. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
1 (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1916, to Jan 19 1916, that I last saw her alive on Jan 19 1916, and that death occured on the date stated above, at 4:25 P.M.

The CAUSE OF DEATH* was as follows:
Puerperal Eclampsia

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Pregnancy with Nephritis.
(Duration ..... yrs. 8 mos. ..... ds.
(Signed) J. T. Reynolds M. D.
1/19 1916. (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kuna Idaho
DATE OF BURIAL: 1-22 1916

20. UNDERTAKER: D Bucknum
ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13635
Registered No. /
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Latah
City of Genesee
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6
Primary Registration District No. 2172
(No. ....., ... St.)

2. FULL NAME Harry Flower

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH
January (Month) 1 (Day) 1916 (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..6.. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Genesee Idaho

10. NAME OF FATHER
John F. Flower Jr

11. BIRTHPLACE OF FATHER
(State or Country) New York

12. MAIDEN NAME OF MOTHER
Alma Gehrke

13. BIRTHPLACE OF MOTHER
(State or Country) Blue Earth Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John F. Flower Jr
(Address) Genesee Idaho

15.
Filed Jan 2d 1916 W. H. Thorn
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916, to Jan 1 1916, that I last saw h alive on Jan 1 1916, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C J Thorn M. D.
1-2 1916 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lutie Cem	1-2 1916

20. UNDERTAKER	ADDRESS
J E Lambert	Genesee Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13636

Registered No. 3

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 6

Primary Registration District No. 212

County of Latah

City of Genesee (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thostrup Halvorson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Dont know exact date
(Month) (Day) (Year)

7. AGE: 72 about yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Dont know

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nels Flamoe
(Address) Genesee Idaho

15. Filed 2-21-1916 W. N. Ekren Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19 1916, to Feb 19 1916, that I last saw h. him alive on Feb 19 1916, and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 5 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Thorny M. D.

Feb 20 1916 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Norwegian Cem	2-21-1916
20. UNDERTAKER	**ADDRESS**
F. E. Lambert	Genesee

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13637
Registered No. 2

1. PLACE OF DEATH.
County of Lake
City of Genesee
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 62
Primary Registration District No. 2142
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francis Kirk Wohl

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept 21 (Month) 1 (Day) 1911 (Year)

7. AGE: 4 yrs. 4 mos. 13 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Genesee Idd

10. NAME OF FATHER: Ed. E Wohl.

11. BIRTHPLACE OF FATHER (State or Country): Genesee Ida

12. MAIDEN NAME OF MOTHER: Ethel Moy Williams

13. BIRTHPLACE OF MOTHER (State or Country): U-S

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S L Wahl
(Address) Genesee Ida

15. Filed 2-5 1916 W. H. Ehrn Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1916, to Feb 3 1916, that I last saw h— alive on Feb. 3 1916, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(Duration) yrs. mos. 14 ds.

Contributory (Secondary) Tuberculosis

(Duration) yrs. mos. 4 ds.

(Signed) C. F. Thorny M. D.

Feb 4 1916 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cem. DATE OF BURIAL: 2-6 1916

20. UNDERTAKER: F. E. Lambert ADDRESS: Genesee Idaho

SYMS - YORK CO., PTRS. & BORS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 125
Primary Registration District No.
(No. ..... St.)

File No. 13638
Registered No. .....

1. PLACE OF DEATH.
County of Jefferson
City of Hamer
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Erastus R Platt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH. Sept (Month) 14 (Day) 1850 (Year)

7. AGE 65 Yrs. 5 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work ...
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) North Carolina

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER (State or Country) Do not know

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Platt
(Address) Dubois Idaho

15. Filed Feb 18 1916 C E Jones M D Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 17th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1916, to Feb 17 1916, that I last saw him alive on Feb 1 1916, and that death occured on the date stated above, at 11.45 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 15 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C E Jones M. D.
Feb 18 1916 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Dubois Idaho — DATE OF BURIAL Feb 20 1916

20. UNDERTAKER None — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRD - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13639
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of Dubois
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph N Fehl Haber

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): at home

6. DATE OF BIRTH. Oct (Month) 6 (Day) 1915 (Year)

7. AGE Yrs. 4 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... at home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wm F Fehl Haber

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Mattie L Tipton

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm F Fehl Haber
(Address) Dubois Idaho

15. Filed Feb 18. 1916 C E Jones M D Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1916, to Feb 18 1916, that I last saw him alive on Feb 17 1916, and that death occured on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:

Acute indigestion

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C E Jones M. D.
Feb 18 1916 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Idaho — DATE OF BURIAL: Feb 20 1916

20. UNDERTAKER: C E Dimmoody — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & STNRS. 24953

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 2086
(No. ....., ... St.)

File No. 13640
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lew Leroy Wacker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M	W.	

6. DATE OF BIRTH: 1 (Month) 21 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 21 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Filer Ida

10. NAME OF FATHER Arthur Wacker

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Blanche Phelps.

13. BIRTHPLACE OF MOTHER (State or Country) Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A A Newberry
(Address) Filer Ida

15. Filed 2-11 1916 A A Newberry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 2 (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1916, to Feb 11 1916, that I last saw h pm alive on Feb 10 1916, and that death occurred on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A A Newberry M. D.
19..... (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Filer Cemetery	2-12 1916

20. UNDERTAKER	ADDRESS
Arthur Wacker (Actng)	Filer Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 3086.
File No. 13641
Registered No. ....

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John D. Fisher

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June 24 1849
(Month) (Day) (Year)

7. AGE: 66 Yrs. 8 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurseryman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Jasper - Dy Boise Ind

10. NAME OF FATHER: Dr Wm S Fisher

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Jane N Hatfield

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs M. Fisher
(Address) Filer

15. Filed 2-20 1916 A A Newberry Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24652

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 11—1915, to Feb. 18 1916, that I last saw him alive on Feb. 17—1916, and that death occured on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) 18 Yrs. ..... mos. ..... ds.

Contributory (Secondary): Arterio-sclerosis

(Duration 10 yrs. ..... mos. 0 ds.

(Signed) Frank A Durgin M. D.

2-18-1916 (Address) Filer Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: F E Drake — DATE OF BURIAL: Feb 19 1916

20. UNDERTAKER: Filer Cemetery — ADDRESS: Filer Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13642

Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 7011

(No. Wallace Hospital St.)

2. FULL NAME Alfred Rouse

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 67 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed JAN 31 1916 191.... F Leo Dunlop Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1916, to Jan 27 1916, that I last saw h[illegible] alive on Jan 27 1916, and that death occured on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Exposure & old age

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Maguire M. D.

1/30 1916 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Jan 31 1916

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

Primary Registration District No. 1014

File No. 13643

County of Shoshone

City of Wallace (No. Providence Hospital St.)

Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W. D. Utterback

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: about 45 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): unknown

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. E. Ward

(Address) Wallace Ida

15. JAN 31 1916

Filed 191

F Leo Jungbluth
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1916, to Jan 23 1916, that I last saw him alive on Jan 23 1916, and that death occured on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary): Exhaustion

(Duration) yrs. mos. ds.

(Signed) D. H. Mowery M. D.

1/30 1916 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence: Burke Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Jan 31 1916

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BOOK. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13644
Registered No. 16

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 191
(No. Hope Hospital St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME James Edward O'Leary

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Sept (Month) 25 (Day) 1881 (Year)
7. AGE: 34 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry business or establishment in which employed (or employer): Confectionery Store
9. BIRTHPLACE (State or Country): Illinois
10. NAME OF FATHER: James O'Leary
11. BIRTHPLACE OF FATHER (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Nellie Campbell
13. BIRTHPLACE OF MOTHER (State or Country): Illinois
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John E. O'Leary
(Address) Spokane Wash
15. Filed JAN 31 1916 191... F. Leo Tunney Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 30 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1916, to Jan 30 1916, that I last saw him alive on Jan 30 1916, and that death occurred on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) Wm T. Smith M. D.
Jan 31 1916 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash
DATE OF BURIAL: Friday 1 1916
20. UNDERTAKER: B.G. Worstell
ADDRESS: Wallace Id

ment of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13645
Registered No. 17

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Charles Miech

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE 51 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mill man
(b) General nature of industry business or establishment in which employed (or employer): Quarty Mill

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Not given

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lunicy Mundy
(Address) Gem Ida

15. Filed JAN 31 1916, 191...
J. Leo Lundy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan 28 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1916, to Jan 28 1916
that I last saw him alive on Jan 28 1916
and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Acute Myocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Leo Lundy M. D.
Jan 30 1916 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. Providence Hosp 10 P In the State 17 yrs. ..... mos. ..... ds. County Wallace
Where was disease contracted, if not at place of death? Gem Idaho
Former or usual residence Gem Idaho

19. PLACE OF BURIAL OR REMOVAL: Chicago Ill
DATE OF BURIAL: July 1st 1916

20. UNDERTAKER: D G Mosteller
ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 1011
File No. 13646
Registered No. 18

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Patrick Dunphy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 51 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Foundland

10. NAME OF FATHER: Thos. Dunphy

11. BIRTHPLACE OF FATHER (State or Country): New Foundland

12. MAIDEN NAME OF MOTHER: Ellen Morsey

13. BIRTHPLACE OF MOTHER (State or Country): New Foundland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Dunphy
(Address) Burke Idaho

15. Filed JAN 31 1916 191...
F. Leo Quinlan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1916, to Jan 26 1916,
that I last saw him alive on Jan 27 1916,
and that death occured on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:
Labar Pneumonia

(Duration) Yrs. mos. 5 ds.
Contributory (Secondary) Exposure
(Duration) yrs. mos. ds.

(Signed) D.D. Mowry M. D.
1/30 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace
DATE OF BURIAL: Jan 31 1916

20. UNDERTAKER: Ward Und Co
ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOK. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hospital St.)

File No. 13647
Registered No. 79

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George McClanahan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: about 70 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): unknown

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. E. Ward
(Address) Wallace Ida

15. Filed JAN 31 1916 191 F. Leo Linder Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 22. 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 21 1916., to Jan. 22. 1916, that I last saw h. alive on Jan 22 1916 and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Accident,

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Hogan M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Hamilton Mont. DATE OF BURIAL: Jan 31 1916

20. UNDERTAKER: Ward Und Co ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13648

Registered No. 1

1. PLACE OF DEATH.

County of Shoshone

City of Wallace (No. Wallace Hospital St.)

Registration District No. 70

Primary Registration District No. 1011

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Hays

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 65 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: nurse
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. E. Ward
(Address) Wallace Idaho

15. Filed Jan 4 1916 F Leo Lungren Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1915, to Jan 2 1916, that I last saw h[er] alive on Jan 2 1916, and that death occured on the date stated above, at 6P M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (Duration) — Yrs. — mos. — ds.

Contributory (Secondary) Senility

..... (Duration — yrs. — mos. ..... ds.

(Signed) Chas E. Hoffman M. D.

Jan 8 1916 (Address) Burke Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence: Wardner Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Jan 4 1916

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13649

Registered No. 2

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011

(No. Providence Hosp't St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 52 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James L. Thomas

(Address) Butte, Montana

15. Filed JAN 5 1916 191.....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 3rd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28, 1915, to Jan 3 1916, that I last saw h-- alive on Jan 3 1916, and that death occured on the date stated above, at 10 30 P.M.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Infected Hand

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) D. McGowery M. D.

1916 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Burke Ida

19. PLACE OF BURIAL OR REMOVAL: Butte Mont — DATE OF BURIAL 191.....

20. UNDERTAKER: Ward Hurd Co. — ADDRESS Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13650

Registered No. 3

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 104

(No. Hope Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry R. Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 52 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Edward C. Hall

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Margaret Leashure

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E Hall

(Address) Enaville

15. Filed JAN 5 1916 191.....

F. Leo Jenkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/1/16 191..., to 1/4/16 191..., that I last saw him alive on 1/4/16 191..., and that death occured on the date stated above, at 2.30 P. M.

The CAUSE OF DEATH* was as follows:

1st Pneumonia - Lobar

(Duration) ... Yrs. ... mos. 7 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Edward C. Hansen M. D.

19.... (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Murray Ida

19. PLACE OF BURIAL OR REMOVAL: Nuccio 2da — DATE OF BURIAL: Jan 6 1916

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace 2da

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BNRS. 24653

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 13650--

Name Henry R. Hall

Date of Death January 4th, 1916

Cause of Death Locomotor Ataxia

Contributary Cause of death

(Sign here) Edward E. Hunter, M.D.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13651
Registered No. 4

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
Registration District No. 10
Primary Registration District No. 1011
(No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Thyne

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH: Feby (Month) 2 (Day) 1854. (Year)

7. AGE: 61 yrs. 11 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Massachusetts

10. NAME OF FATHER: Ralph Thyne

11. BIRTHPLACE OF FATHER (State or Country): not given

12. MAIDEN NAME OF MOTHER: Mary Lyons

13. BIRTHPLACE OF MOTHER (State or Country): Not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James T. Thyne
(Address) Wace, Idaho.

15. Filed JAN 7 1916 191...
F. Lea Dunphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11th 1915, to June 4 1916
that I last saw him alive on " 4 1916
and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:

Empyema

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. S. Stone M. D.
June 7th 1916. (Address) Mullan Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace, Idaho
DATE OF BURIAL: 1- 7 1916

20. UNDERTAKER: Bruce G. Worstell.
ADDRESS: Wallace, Id

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13652
Registered No. 5

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1001
(No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Patrick Skelly,

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 78 yrs. -- mos. -- ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W B Flood
(Address) Mullan, Idaho

15. Filed JAN 7 1916 191...
F Leo Jumley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 6 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1915, to Jan 6 1915
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows: Acute dilitation of heart

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteriosclerosis
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F Leo Jumley M. D.
Jan 7, 1916 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane, Washington
DATE OF BURIAL: Jan. 10th 1916.

20. UNDERTAKER: Bruce & Worstell
ADDRESS: Wallace, Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 1011
File No. 13653
Registered No. 6

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bert Kingsbury

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 30 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): unknown

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. E. Ward
(Address) Wallace Ida.

15. Filed Jan 11 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 5 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1916, to Jan 5 1916, that I last saw h.. alive on Jan 5 1916, and that death occured on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) Dr. Howard M. D.
13 1916 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence: Helena Montana

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Jan 11 1916

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13654

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Wallace (No. Hope Hospital St.)

Registration District No 10

Primary Registration District No 1011

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oscar Liljenberg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 35 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: August Johnson Liljenberg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Lena Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gus Liljenberg

(Address) Wal Liljenberg

15. Filed Jan 14 1916 [signature] Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24058

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 12th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1915, to Jan 12th 1916, that I last saw h alive on Jan 12 1916, and that death occured on the date stated above, at 8.30 P.M.

The CAUSE OF DEATH was as follows:*

Lobar pneumonia

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) [signature] M. D.

19 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Swedesburg-Minn

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Jan 14 1916

20. UNDERTAKER: Ford Hurd Co — ADDRESS: Wallace Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13655

Registered No. 6

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 10

Primary Registration District No. 1911

(No. Hope Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gordon Lunan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: about 9 5 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): unknown

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. E. Ward

(Address) Wallace Ida

15. Filed Jan 14 1916

F Leo Funke
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/31/15 1915, to 1/10/16 1916, that I last saw him alive on 1/9/16 1916, and that death occured on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia.
Lobar

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank C. Thurm. M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence Eckelsdale Mine

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Jan 14 1916

20. UNDERTAKER: Ward Hdw Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

-SUPPLEMENARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 13655--

Name Gordon Linsay

Date of Death January 10th, 1916

Cause of Death [illegible]

Contributary Cause of death [illegible]

(Sign here) [illegible] M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13657

Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 70

Primary Registration District No. 104

County of Shoshone

City of Wallace (No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Jaeger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE 48 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Cook

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Peters

(Address) Wallace Ida

15. Filed JAN 15 1916 191 ..... F Leo Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) Jan. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1915, to Jan 12 1916, that I last saw h[e] alive on Jan 11 1916, and that death occured on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows:

Alcoholism

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Depravation Edema

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. G. Dillman M. D.

Jan 15 1916 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Wallace Ida

19. PLACE OF BURIAL OR REMOVAL Wallace — DATE OF BURIAL Jan 15th 1916

20. UNDERTAKER Hart Hurd Co — ADDRESS Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1/19/16

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & STNRS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13658
Registered No. 10

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 6104
(No. Providence Hospital St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Ray Mansell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 6 (Day) 1878 (Year)

7. AGE: 38 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mt. Sterling Ky

10. NAME OF FATHER: No

11. BIRTHPLACE OF FATHER (State or Country): No

12. MAIDEN NAME OF MOTHER: No

13. BIRTHPLACE OF MOTHER (State or Country): No

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. N. Bain
(Address) Wallace Ida

15.
Filed Jan 18 1916
F Leo Jennings
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 17th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 12 1916, to January 16 1916
that I last saw him alive on January 16 1916
and that death occurred on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) yrs. mos. 3 ds.
Contributory (Secondary) Exposure
(Duration) yrs. mos. ds.

(Signed) Wm Mowery M. D.
1/18 1916 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Prov Hospital — yrs. — mos. 3 ds. In the town of Wallace State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? Gem Idaho
Former or usual residence Gem Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: Jany 18 1916
20. UNDERTAKER: B G Worstell
ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13659
Registered No. 11

1. PLACE OF DEATH.
County of Shoshone
City of Frisco

Registration District No. 10
Primary Registration District No. 1011
(No. Frisco Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thiostheus Laurence

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 23 (Day) 1880 (Year)

7. AGE: 35 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Timothy Laurence

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Catherine Paquet

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Laurence
(Address) Frisco Idaho

15. Filed JAN 24 1916 191
F. Leo Lindley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1915, to Jan 1916, that I last saw h alive on Dec 1915 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)
(Duration) Dr mos. ds.

(Signed) D. Mowry M. D.
Jan 22 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace, Idaho.
DATE OF BURIAL: Jany 24 1916

20. UNDERTAKER: B. G. Wortell
ADDRESS: Wallace, Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13660

Registered No. 12

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No 10

Primary Registration District No 104

(No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Luther M. Mahan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 41 Yrs. — Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Okla.

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hugh Gibson

(Address) Burke, Idaho

15. Filed JAN 24 1916 191.... F Leo Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 19 — 1916, to Jan 19 1916, that I last saw him alive on Jan. 19 1916, and that death occured on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Nov. 19-1915 —

Tuberculosis

..... (Duration) ..... Yrs. 2 mos. — ds.

Contributory (Secondary) .....

..... (Duration ..... Yrs. — mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? Went Home

Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Jan 24 1916

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 15
Primary Registration District No.
(No. ....., ... St.)

File No. 13661
Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Boise
City of McCall

2. FULL NAME Mary Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. June (Month) 24 (Day) 1848 (Year)

7. AGE: 68 Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Jack Ojala

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Mary Pniita

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed Jan 29 1916. Ruth McDonel Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 18 1916, to Jan. 28 1916, that I last saw her alive on Jan. 18 1916, and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Apoplexy -
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) D. H. Compton M. D.
1/27 1916 (Address) Rosebud Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jin Cemetery — DATE OF BURIAL: 2/1 1916

20. UNDERTAKER: A Kumpula — ADDRESS: McCall

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & SDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 15
Primary Registration District No.
(No. , St.)

File No. 13662
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bear Lake
City of Bonnelly
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Pottenger

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 4 (Day) 1849 (Year)

7. AGE: 66 Yrs. 9 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Porter Co. Ind.

10. NAME OF FATHER: Joseph McConnell

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Edith Lee

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): James M. Pottenger
(Address): Rosebury

15. Filed Feb. 3 1916 Rich. McDonald Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1st 1912, to Jan. 29 1916, that I last saw h Ex alive on Jan 31st 1916, and that death occured on the date stated above, at Died in Shop Exact hour unknown M.
The CAUSE OF DEATH* was as follows:
Mitral Valvular Lesion and Uremia Complicated with Dropsy
4 Years (Duration) Yrs. mos. ds.
Contributory (Secondary) Uremia & Dropsy
(Duration 3 yrs. mos. ds.
(Signed) F. N. Compton M. D.
2/3 1916 (Address) Rosebury Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Homes Cemetery — DATE OF BURIAL: 2/3 1916

20. UNDERTAKER: D. M. Cat — ADDRESS: Rosebury

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13664

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bear Lake
City of St. Charles
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 54
Primary Registration District No.

2. FULL NAME Mary Jane Stewart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: May (Month) 22 (Day) 1844 (Year)

7. AGE: 71 yrs. 8 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Patterson, New Jersey

10. NAME OF FATHER: Benjamin Taylor

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Ann Brown

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Stewart
(Address) St. Charles

15. Filed Feb 23 1916 John Matson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 19th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Infirmities of old age.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Charles
DATE OF BURIAL: Feb. 22nd 1916

20. UNDERTAKER: J. A. Blade
ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25, M. 1-16-13

Item 6 & 7 amended 11-21-85 fc

CERTIFICATE OF DEATH.

Registration District No. 88

Primary Registration District No. 2164

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13665

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Cambridge

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melvin L Edington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. October 30, 1914
(Month) Feb (Day) 25 (Year) 1916

7. AGE: Yrs. 1 Mos. 7 Ds. 26
15 months
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Thomas L Edington

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Flora Fraze

13. BIRTHPLACE OF MOTHER (State or Country) Oklahoma Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E L Edington
(Address) Cambridge Idaho

15. Filed Feb 25 1916

O E Schmitt
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1916, to Feb 25 1916, that I last saw him alive on Feb 24 1916, and that death occured on the date stated above, at 3:40 A.M.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(Duration) ..... Yrs. ..... mos. 2 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O E Schmitt M. D.

Feb 25 1916 (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nelubrin Idaho — DATE OF BURIAL: Feb 26 1916

20. UNDERTAKER: Jas Hudelson — ADDRESS: Cambridge Idaho

9-26-85

IDAHO DEPARTMENT OF HEALTH AND WELFARE
Bureau of Vital Statistics, Standards, and Local Health Services

AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

RECEIVED
BUREAU OF
VITAL STATISTICS
NOV 21 3 49 PM '85

State of _____
County of _____ } ss.

Certificate No. 13665
Date Filed _____

The undersigned does solemnly swear that certain facts on the certificate of death

for Melvin Ledington (Name on Original Certificate) who died (Was Born, Died, etc.) on Feb 25, 1916 (Date of Event)

in Washington County (Place of Event) are erroneous or were omitted:

ITEMS TO BE CORRECTED	FROM	TO
birth date	Feb 25, 1916	Oct 30, 1914
age	17 mos	15 mos 26 days

Subscribed and sworn to before me this 2nd day of October, 1985

Notary Public, Susan L. Glazer

Residing at 1421 N. Loop W. Hou. Tx 77008

My commission expires 4-6-86

(Seal)

Dorothy E. Anderson
Signature of Applicant

1518 Cheshire - Houston Texas 77018
Street Address, City, State

(sister) of Melvin Ledington

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Texas
County of Harris } ss.

(Must be completed __)
(Is not necessary __)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 2nd day of October, 1985.

Notary Public, Susan L. Glazer

Residing at 1421 N. Loop W. Hou Tx 77008

My commission expires SUSAN GLAZER Notary Public, State of Texas My Commission Expires 4-6-86

(Seal)

Supporting Signature

Street Address, City, State

return to dl

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Washington
City of Cambridge
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 88
Primary Registration District No. 2164
(No. ....., ... St.)

File No. 13666
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ellis Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH: Feb (Month) 25 (Day) 1916 (Year)

7. AGE: 87 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Inmate of Poor Farm
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry C. Lyons
(Address) Cambridge Ida

15. Filed Feb 26 1916. O E Schmidt, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1916, to Jan 22 1916, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Heart Lesion / Mitral Regurgitation

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. D. Douglas Hospital M. D.
19.... (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cambridge Ida	Feb 26 1916

20. UNDERTAKER	ADDRESS
Jas Hudelson	Cambridge Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-33 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2072
File No. 13668
Registered No. .....

1. PLACE OF DEATH.
County of Power
City of Am Falls
(No. .... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evelines S. Carrier
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or widowed)

6. DATE OF BIRTH. May (Month) 8 (Day) 1844 (Year)

7. AGE: 71 Yrs. 9 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: John H. Bartlett

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Dolly Fogg

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Walter W. Currier
(Address) American Falls, Ida.

15. Filed Feb 9 1916 — R. T. Hait, Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1916, to Feb 15 1916, that I last saw her alive on Feb 15 1916, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorhage

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Richard T. Hait M. D.

2/17 1916 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bellingham Bay Wash. — DATE OF BURIAL: 2/20 1916

20. UNDERTAKER: H R Hager — ADDRESS: Am Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13669

Registered No. .....

Registration District No. 25

Primary Registration District No. 2072

1. PLACE OF DEATH.

County of Power

City of Am Falls

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Whaley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write Which): Married

6. DATE OF BIRTH. Nov (Month) 12 (Day) 1840 (Year)

7. AGE: 75 Yrs. 2 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Iron Worker

9. BIRTHPLACE (State or Country) Delaware

10. NAME OF FATHER James Whaley

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Mary Burkson

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Myrtle Whaley

(Address) American Falls Ida

15. Filed Jan 25 1916

R. F. McKay
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1916, to Jan 21 1916, that I last saw h[im] alive on Jan 21 1916, and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Grippe Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) V

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Richard F. Voth M. D.

1/21 1916 (Address) American Falls.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Seattle Wash — DATE OF BURIAL: Jan 24 1916

20. UNDERTAKER: H. K. Hager — ADDRESS: Am Falls.

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2077
File No. 13670
Registered No. .....

1. PLACE OF DEATH.
County of Power
City of American Falls (No. .... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William A. Raff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 11 (Day) 1867 (Year)

7. AGE: 48 Yrs. 2 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Minister of the
(b) General nature of industry, business, or establishment in which employed (or employer)... Gospel

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER W. Raff

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. Graner Pastor
(Address) Am. Falls, Ida.

15. Filed Feb 10 1916 R. F. Northcutt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 4th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1915, to Feb 4 1916, that I last saw h[illegible] alive on Feb 2nd 1916, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Paresis

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Reuben F Northcutt M. D.

2/4 1916 (Address) Am Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: American Falls — DATE OF BURIAL: Feb 6 1916

20. UNDERTAKER: Fred Bentz — ADDRESS: Am Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2072
File No. 13671
Registered No. .....

1. PLACE OF DEATH.
County of Power
City of American Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes Esau

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. July (Month) 12 (Day) 1850 (Year)

7. AGE: 65 Yrs. 7 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Cornelius Fast

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Agnes ——

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs H. N. Janzen (daughter)
(Address) American Falls Idaho

15. Filed Feb 24 1916 A. F. Mock Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7th 1915, to Feb 22nd 1916, that I last saw h.e alive on Feb 22nd 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Ovarian Cyst.
about
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Chronic interstitial Nephritis
(Duration) about 1/2 yrs. mos. ds.
(Signed) Richard F Mock M. D.
2/24 1916 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 4 mos. 15 days. In the State 8 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Aberdeen Idaho
Former or usual residence Aberdeen Idaho

19. PLACE OF BURIAL OR REMOVAL: Aberdeen
DATE OF BURIAL: Feb 27 1916

20. UNDERTAKER: A R Hagen
ADDRESS: Am. Falls Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2072
File No. 13672
Registered No. .....

1. PLACE OF DEATH.
County of Boise
City of Am Falls.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosa Jacht Litz.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married
6. DATE OF BIRTH. April (Month) 21 (Day) 1877 (Year)
7. AGE: 38 Yrs. 9 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: August Jacht
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Catherine Vetter
13. BIRTHPLACE OF MOTHER (State or Country): Germany
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) August Litz
(Address) Am Falls
15. Filed Jan 13 1916 R. F. Work, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 11 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1915, to Jan 11 1916, that I last saw her alive on Jan 11 1916, and that death occured on the date stated above, at 8:30 P.M.
The CAUSE OF DEATH* was as follows:
Influenza
(Duration) Yrs. ..... mos. 7 ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. 15 ds.
(Signed) Richard F Work M. D.
1/13 1916 (Address) Am Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emery S. Dak. — DATE OF BURIAL: Jan 16 1916
20. UNDERTAKER: F. Bentz — ADDRESS: Am Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13674
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Bovill
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gerald Alvin Veole

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Aug (Month) 19 (Day) 1907 (Year)

7. AGE: 8 yrs. 5 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada Minn.

10. NAME OF FATHER: ~~X~~ Wilhelm Velve

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Anna Njalde

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ole Velve
(Address) Elk River Ida

15. Filed 7/8 1916 J. L. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 7 (Month) — 8 (Day) — 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/8 — 1916, to 7/8 — 1916, that I last saw him alive on 7/8/ 1916, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. 15 ds.
Contributory (Secondary) Acute Art Rheumatism
(Duration) 4 yrs. mos. ds.

(Signed) F. C. Gibson M. D.
7/9/1916 (Address) Bovill

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elk River Ida | DATE OF BURIAL 191

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

County of Latah — Registration District No. 26 — Bureau of Vital Statistics

City of Bovill — Primary Registration District No. 2146 — File No. 12871

(No. ....., ... St.) — Registered No. REUSED

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gerald Albin Velure

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

The information on this certificate is an exact COPY of the official certificate filed at place of death.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male | 4. COLOR OR RACE: White | 5. Single, Married, Widowed or Divorced. (Write the Word): Single

6. DATE OF BIRTH. Aug (Month) 19th (Day) 1917 (Year)

7. AGE: 8 Yrs 5 Mos 28 ds. — IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada. Minn

10. NAME OF FATHER: Wilhelm Velure

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Anna Njelde

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Ole Velure
(Address): Elk River Ida

15. Filed 7/8 1916 J. L. Champion Local Registrar.

Place Where Remains are to be Sent: Elk River Ida — Date of Shipment 7/9 1916

SHIPPING UNDERTAKER J. E. Record

ADDRESS Troy Idaho Firm Name

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Feb (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/8 1916, to 2/8 1916, that I last saw him alive on 2/8 1916, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH was as follows:

Myocarditis.

(Duration) ..... Years ..... mos. 5 ds.

Contributory (Secondary) Acute Art. Rheumatism

(Duration) ..... Years ..... mos ..... ds.

(Signed) J. L. Champion M. D.

2/8 1916. (Address) Bovill

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)
At place of death ....yrs....mos....days — In the State ....yrs...mos...days

Where was disease contracted if not at place of death

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elk River Ida — Date of Burial ....191...

20. UNDERTAKER: J. L. Champion — Address: Bovill Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 4

Primary Registration District No. 1005

(No. ..... ; ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13676

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Payette

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 3 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..6.. hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Payette Ida

10. NAME OF FATHER H. H. Grimm

11. BIRTHPLACE OF FATHER (State or Country) Kan

12. MAIDEN NAME OF MOTHER Anna Mae Rosa

13. BIRTHPLACE OF MOTHER (State or Country) Cal

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. H. Grimm

(Address) Payette Ida

15. Filed Feb 5 1916. J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1916, to Feb 3 1916, that I last saw him alive on Feb 3 1916, and that death occured on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Unknown

.....(Duration) ..... Yrs. ..... mos. 6 hrs. ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Avery M. D.

2/4/1916 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: Feb 4 1916

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNE - YORK CO., PTRS. & BDRS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 13677
Registered No. 12

1. PLACE OF DEATH.
County of Canyon
City of Payette
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ann Strauss

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: Sept 23 1834 (Month) (Day) (Year)

7. AGE: 81 yrs. 4 mos. 23 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Daniel Hoffman

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna Coleman

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. V. Strauss Husb.
(Address) Payette Idaho.

15. Filed Feb. 14 1916 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 14 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1914, to Feb. 13 1916, that I last saw her alive on Feb. 13 1916, and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:
Cancer of throat.

(Duration) yrs. 2 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) O. H. Avey M. D.
2/14/1916 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence: Removal

19. PLACE OF BURIAL OR REMOVAL: Logan Iowa | DATE OF BURIAL: Feb 15 1916

20. UNDERTAKER: D. A. Adair | ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 4

Primary Registration District No. 1008

(No. .... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13678

Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Payette

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elizabeth Roberts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: March (Month) 16 (Day) 1876 (Year)

7. AGE: 39 Yrs. 11 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Henry Co. Mo.

10. NAME OF FATHER: Samuel Burt.

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary Summers.

13. BIRTHPLACE OF MOTHER (State or Country): Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Celia V. Roberts

(Address) Payette Idaho

15. Filed Feb 21 1916

J C Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1916 to Feb 19 1916, that I last saw h alive on Feb 19 1916 and that death occured on the date stated above, at 11 00p M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Woodward M. D.

Feb 21 1916 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: Feb 22 1916

20. UNDERTAKER: Glenn C Landon. — ADDRESS: Payette Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13679

Registered No. 14

1. PLACE OF DEATH.

County of Canyon

City of Payette

Registration District No. 4

Primary Registration District No. 1008

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas H Solders

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Feb (Month) 13 (Day) 1842 (Year)

7. AGE: 74 Yrs. ..... Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER Solders

11. BIRTHPLACE OF FATHER (State or Country) unknowed

12. MAIDEN NAME OF MOTHER Unknowed

13. BIRTHPLACE OF MOTHER (State or Country) Unknowed

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank L Solders

(Address) Fruitvale Idaho

15. Filed Feb 27 1916 J C Woodward Local Registrar

2/27

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19 1916, to Feb 26 1916, that I last saw him alive on Feb 24 1916, and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

(Duration) ..... Yrs. ..... mos. 7 days ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J C Woodward M. D.

1916 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: Feb 28 1916

20. UNDERTAKER: Glenn C. Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13680
Registered No. 15

Registration District No. 4
Primary Registration District No. 1008
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Payette

2. FULL NAME Emma Shaw

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 4 (Day) 1849 (Year)

7. AGE: 66 Yrs. 11 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Home Keeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Ill

10. NAME OF FATHER: Geo Farbis

11. BIRTHPLACE OF FATHER
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER: Sarah Welch

13. BIRTHPLACE OF MOTHER
(State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Will Wells
(Address) Payette

15. Filed March 1 1916 J C Woodward Local Registrar

SYMS - YORK CO., PTRS. & BOXS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1916, to Feb 28 1916, that I last saw h[illegible] alive on Feb 28 1916, and that death occured on the date stated above, at 11 30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Indefinite
(Duration) ..... Yrs. ..... mos. ..... ds.
~~Contributory~~ (Secondary) Acute cystitis
(Duration) ..... yrs. ..... mos. 14 ds.
(Signed) C A Barton M. D.
3-1 1916 (Address) Payette

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: March 1 1916

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 13681
Registered No. 18

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Allison Alfred Baller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH: 4 (Month) 9 (Day) 1915 (Year)

7. AGE: ..... yrs. 10 mos. 9 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Pallatch Idaho

10. NAME OF FATHER William Baller

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Emma Leuthaud

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rosa L. Schmidt
(Address) Moscow Idaho.

15. Filed Feb 18 1916 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4:00 pm - 2-18 1916, to 6:30 pm 2-18 1916, that I last saw him alive on 6:00 pm. 2-18 1916 and that death occurred on the date stated above, at 6 p. M.

The CAUSE OF DEATH* was as follows:
Gastroenteritis -

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Artificial feeding

..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. V. Gilman M. D.
2-18 1916 (Address) Moscow, Idaho -

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pallatch Idaho	1916
20. UNDERTAKER	**ADDRESS**
Geo C Grice	Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 13682
Registered No. 22

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mch (Month) 3 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many 17 hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Moscow Idaho

10. NAME OF FATHER: A G McIlwreath

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Margret Block

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A G McIlwreath
(Address) Moscow

15. Filed Mch 4 1916 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 3 1916, to Mch 4 1916, that I last saw her alive on Mch 4 1916, and that death occurred on the date stated above, at 3.0 A.M.

The CAUSE OF DEATH* was as follows:
Inanition
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Premature birth
(Duration) 8 months yrs. ..... mos. ..... ds.
(Signed) D F Rae M. D.
4/3/1916 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Mch 5 1916

20. UNDERTAKER: Home Father acting — ADDRESS: Moscow

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13683

Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Moscow

(No. ....., ... St.)

Registration District No. 61

Primary Registration District No. 1011

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Johnson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Oct (Month) 24 (Day) 1829 (Year)

7. AGE: 86 Yrs. 4 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9. BIRTHPLACE (State or Country): Sweeden

10. NAME OF FATHER: Andrew Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. E. Lundquist

(Address) Moscow Idaho

15. Filed Mch 3 1916 S. T. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1910, to March 2 1916, that I last saw her alive on March 1 1916, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Epithelioma of face

Cancer

(Duration) 5 Yrs. mos. ds.

Contributory (Secondary) General Debility

(Duration yrs. mos. ds.

(Signed) Joseph Despain M. D.

3-3 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 3/4 1916

20. UNDERTAKER: Glen O Guice — ADDRESS: Moscow

SVMS - YORK CO., PTRS. & SONS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 13684
Registered No. 20

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. County Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Hass.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Not Known (Month) (Day) 1873 (Year)

7. AGE: 43 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New Brunswick

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. H. Carithers
(Address) Moscow
County Physician

15.
Filed Mch 3 1916 D. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mch (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1 1916, to Mch. 1" 1916, that I last saw him alive on Feb 27" 1916, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Valvular Insufficiency (Heart)

(Duration) 6 Yrs. — mos. — ds.

Contributory (Secondary) Rheumatism.

(Duration) 1 yrs. — mos. ..... ds.

(Signed) W. H. Carithers M. D.

3-3 1916 (Address) Moscow, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 1 mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Mch 3rd 1916

20. UNDERTAKER: Glen O Grice — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 13685
Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Nathan Buchanan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 2 (Day) 1857 (Year)

7. AGE: 58 Yrs. 10 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Same

9. BIRTHPLACE (State or Country): Newton Co. Ms.

10. NAME OF FATHER: Nathan Buchanan

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Diana Sutherland

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ernest Randall
(Address) Moscow Idaho

15. Filed Mch 1 1916 D. F. Rae Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1913, to Feby 29 1916, that I last saw h[illegible] alive on ..... 1916 and that death occured on the date stated above, at 4 30 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic interstitial Nephritis
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Fortman M. D.
3/1 1916 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buchanan Cemetary — DATE OF BURIAL: 3/2 1916

20. UNDERTAKER: Glen O Price — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13686

Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

(No. ....., Gritman Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Jonette Erickson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept. (Month) 29 (Day) 1855 (Year)

7. AGE: 60 Yrs. 4 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Anderson

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Minnie Jonette Anderson

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ella Parkins

(Address) Elk Idaho

15. Filed Feb 23 1916

D F Kane - Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 12 1916, to Feby 22 1916, that I last saw h[er] alive on Feby 22 1916, and that death occured on the date stated above, at 10:55 P.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.

2/23 1916 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 10 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Lewiston, Idaho

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida

DATE OF BURIAL: 1916

20. UNDERTAKER: Glenn Grice

ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13687

Registered No. 16

1. PLACE OF DEATH.

County of Latah

City of Moscow

(No. ..... Own Room Hotel ..... St.)

Registration District No. 61

Primary Registration District No. 6011

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Howard Rahlf

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 21 (Day) 1865 (Year)

7. AGE: 51 Yrs. ..... Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Contractor & Builder Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Builder Carpenter

9. BIRTHPLACE (State or Country): Davenport Iowa

10. NAME OF FATHER: Amos R. Rahlf

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ed Rahlf

(Address) Palouse Wn.

15. Filed Feb 24 1916 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 7.25 A M.

The CAUSE OF DEATH* was as follows:

Apoplexy.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) E B M Barton M. D.

2/24 1916 (Address) Moscow Coroner

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse Washington — DATE OF BURIAL ..... 191...

20. UNDERTAKER: Glen C Green — ADDRESS Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 61

Primary Registration District No. 1011

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13688

Registered No. 16

1. PLACE OF DEATH.

County of Latah

City of 6 miles N.E. of Moscow (Moscow St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Carlson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. May (Month) 31 (Day) 1834 (Year)

7. AGE 81 Yrs. 8 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Paul Carlson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Dont know

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Carlson

(Address) Moscow Ida

15. Filed Feb 18 1916 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 17th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8th 1916, to Feb 16th 1916, that I last saw h[illegible] alive on Feb 13th 1916, and that death occured on the date stated above, at 7:10 A.M.

The CAUSE OF DEATH* was as follows:

Inflammation of bladder

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) Senility

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W A Cedar M. D.

Feb 17 1916. (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	2/19 1916
20. UNDERTAKER Glen O Grieg	ADDRESS Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13689
Registered No. 14

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. 840 East Eighth St.)
Registration District No. 61
Primary Registration District No. 1011
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bessie Lyle Havens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 18 (Day) 1885 (Year)

7. AGE: 30 Yrs. 9 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: James Pogue

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Sodelia Sliff

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ira W. Havens
(Address) Moscow Idaho

15. Filed Feb 15 1916 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1915, to Feb. 14 1916, that I last saw h[illegible] alive on Feb. 14 1916, and that death occured on the date stated above, at 11-P M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) one Yrs. mos. ds.
Contributory (Secondary) ——
(Duration yrs. mos. ds.
(Signed) J. U. Clarke M. D.
2/15 1916 (Address) Moscow

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 2/16 1916

20. UNDERTAKER: Glen A Price — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9

County of Canyon

Primary Registration District No. 2007

City of Parma

(No. ....., ... St.)

File No. 13692

Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leland Sessions

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	Single

6. DATE OF BIRTH: Jan. (Month) 17 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Canyon Co. Idaho

10. NAME OF FATHER Alfred A. Sessions

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Ida Pickard

13. BIRTHPLACE OF MOTHER (State or Country) Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. A. Sessions

(Address) Parma Ida.

15.

Filed Feb. 6 1916 Lucile Waldron Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 17 1916, to Feb. 4 1916, that I last saw him alive on Feb. 4 1916, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Premature development

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. B. Allen M. D.

2-6 1916 (Address) Parma Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Roswell — DATE OF BURIAL: Feb. 5 1916

20. UNDERTAKER: Peckham Casket Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Parma R. 1 (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 8007

File No. 13693
Registered No. 3
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Ezra Lytle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Widowed

6. DATE OF BIRTH: Aug (Month) 7 (Day) 1889 (Year)

7. AGE: 76 yrs. 6 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N Y

10. NAME OF FATHER: Joseph Lytle

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Do not Know

13. BIRTHPLACE OF MOTHER (State or Country): Do not Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Nell Robinson
(Address) Parma Route 3

15. Filed March 1 1916 Lulukalchy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 19 1916, to Feb 28 1916, that I last saw him alive on Feb 21 1916, and that death occurred on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) — yrs. — mos. 9 ds.
Contributory (Secondary) Old age
(Duration) — yrs. — mos. — ds.

(Signed) H. H. Mulcahy M. D.
Feb 29 1916 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Roswell | DATE OF BURIAL: Mch 1 1916

20. UNDERTAKER: Peckham Cane Co | ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13694

Registered No. 6

1. PLACE OF DEATH. Registration District No. 3

County of Canyon Primary Registration District No. 2007

City of Parma R.F.D. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Viola Bartlett

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH: June (Month) 14 (Day) 1848 (Year)

7. AGE: 68 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Jacob Kimball

11. BIRTHPLACE OF FATHER (State or Country): Do not know

12. MAIDEN NAME OF MOTHER: Sarah Willie

13. BIRTHPLACE OF MOTHER (State or Country): Do not know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Willard T. Bartlett
(Address) .....

15. Filed March 2 1916 Luther Waldron Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 29 (Month) (Day) 1916 (Year)

I HEREBY CERTIFY, That I attended deceased from Feb. 21" 1916, to Feb. 29" 1916
that I last saw her alive on Feb. 29" 1916,
and that death occurred on the date stated above, at 4 9. M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Henry M. D.
Mar 1st 1916. (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Linder cemetery — DATE OF BURIAL: March 2 1916

20. UNDERTAKER: Peckham Bros Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 1050

File No. 13695

County of Kootenai

City of Coeur d'Alene (No. ....., ... St.)

Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marian Jean Rockwell

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 1 (Month) 31 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 1 3/4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: F. J. Rockwell

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Clara Shearer

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. J. Rockwell
(Address) Coeur d'Alene, Idaho

15. Filed 2-3 1916 M. L. Morand Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby 2nd (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 31st 1915, to Feby 2 1916, that I last saw h er alive on Feby 2 1916, and that death occurred on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Melena Neonatorum

..... (Duration) ..... yrs. ..... mos. 1/2 ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. H. Most M.D.

Feby 3 1916 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Com. | DATE OF BURIAL: 2-3 1916

20. UNDERTAKER: Cassedy & Nelson | ADDRESS: 209

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD of Vital Statistics
Bureau of Vital Statistics
File No. 13696
Registered No. 47

1. PLACE OF DEATH.
County of Kootenai
City of Post-Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29
Primary Registration District No. 1050
(No. ..., ..., St.)

2. FULL NAME John Hoxie

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Don't know (Month) (Day) 1 (Year)
7. AGE: 76 yrs. ... mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country):
10. NAME OF FATHER: Hoxie
11. BIRTHPLACE OF FATHER (State or Country):
12. MAIDEN NAME OF MOTHER: Don't-Know
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Hoxie
(Address) Post Falls, Idaho
15. Filed 2-4 1916 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 3 (Month) (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct. 28 1915 to Feb. 3 1916, that I last saw h[illegible] alive on Oct 28 1915 and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis (Nephritis)
(Duration) 1 yrs. 6 mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) [illegible] M. D.
Feb 4 1916 (Address) Coeur d'Alene, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cem. DATE OF BURIAL: Feb 5 1916
20. UNDERTAKER: Cassidy & Nelson ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13697

Registered No. 48

1. PLACE OF DEATH.

Registration District No. 29

County of Kootenai

Primary Registration District No. 1050

City of Coeur D'Alene (No. 0, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura F. Mohr

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: July (Month) 25 (Day) 1864 (Year)

7. AGE: 52 yrs. 6 mos. 12 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Levy Smith

11. BIRTHPLACE OF FATHER (State or Country): S Penn.

12. MAIDEN NAME OF MOTHER: Maria Browning

13. BIRTHPLACE OF MOTHER (State or Country): N ——

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J A Mohr

(Address)

15. Filed Feb 6 1916 M. E. Soland. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 1 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 5 1916, to Feb. 1 1916, that I last saw h[illegible] alive on Feb. 6 1916, and that death occurred on the date stated above, at 6h M.

The CAUSE OF DEATH* was as follows:

Progressive Spinal Muscular Atrophy

(Duration) 2 yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) 10 yrs. mos. ds.

(Signed) J O Voyer M. D.

Feb 9 1916 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetary	Feb. 7 1916

20. UNDERTAKER	ADDRESS
Cassedy & Nelson	Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13698

Registered No. 49

Registration District No. 29

Primary Registration District No. 1050

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J H Sinclair

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1837 (Year)

7. AGE: 79 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Sinclair

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Kunnetie Emmons

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) R. A. Sinclair

15. Filed 2-10 1916 J M Poland Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 9th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 8 1916, to Feb 9 1916, that I last saw him alive on Feb 8th 1916, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary): Age —

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jno Busby M. D.

Feb 9 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sunset Cem — DATE OF BURIAL 1916

20. UNDERTAKER: S J Lucas — ADDRESS Coeur d Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 1050

File No. 13699
Registered No. 1
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Dingman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug 22 1852 (Month) (Day) (Year)

7. AGE: 63 yrs. 5 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Wm Dingman

11. BIRTHPLACE OF FATHER (State or Country): Holland

12. MAIDEN NAME OF MOTHER: Tuttle

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jennie Dingman
(Address) Coeur D'Alene

15. Filed 2-16-1916 W. McCausland Local Registrar
Coeur D'Alene

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 13th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8th 1916, to Feb 13 1916, that I last saw him alive on Feb 13th 1916, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. Busby M. D.
Feb 14 1916 (Address) Coeur D'alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary | DATE OF BURIAL: Feb. 15 1916

20. UNDERTAKER: Cassedy & Nelson | ADDRESS: Coeur D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

File No. 13700
Registered No. 2

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A. D. McClaude

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1 (Year)

7. AGE
56 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Canada

10. NAME OF FATHER Duncan McClaude

11. BIRTHPLACE OF FATHER
(State or Country) Scotland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. D. McClaude
(Address) Coeur d'Alene

15. Filed 2-18 1916 J. McLoban
Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 17th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1916, to Feb 17 1916, that I last saw him alive on Feb 16 1916, and that death occured on the date stated above, at 8 9 M.

The CAUSE OF DEATH* was as follows:

Cardiac Dyspepsia due to Chronic alcoholism

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jas Busby M. D.

Feb 19 16 (Address) Coeur D'alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	Feb. 20th 1916
20. UNDERTAKER T. C. Kidd	ADDRESS C.D.A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13701
Registered No. 3

Registration District No. 29
Primary Registration District No. 1050

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Patrick Joseph Garner

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH
Jan. (Month) 14 (Day) 1868 (Year)

7. AGE
48 yrs. 1 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Stonemason
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Minn.

10. NAME OF FATHER Richard Garner

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Rose Barrett

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. J. Donegan
(Address) Coeur D'Alene

15.
Filed 2-21 1916 M. E. Brand
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
2 (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1915, to 2-5 1916
that I last saw him alive on 2-5 1916
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of lower jaw.

(Duration) 2 yrs. mos. ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. E. Brand M. D.
2-20 1916 (Address) Cd Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St. Thomas Cemetary	Feb 24 1916

20. UNDERTAKER	ADDRESS
Cassedy & Nelson	Coeur D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No. 29

Primary Registration District No. 1050

(No. ....., ... St.)

File No. 13702

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice J. Newton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Mar. (Month) 4 (Day) 1888 (Year)

7. AGE: 27 Yrs. 9 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Eugene Oregon

10. NAME OF FATHER: J. R. Coultas

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Alice Woods.

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wesley C. Newton

(Address) 905 Young St.

15. Filed 2-22 1916 W. McFarland Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 22nd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1914, to Feb 22 1916, that I last saw her alive on Feb 20 1916, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jno Busby M. D.

19..... (Address) Coeur D'alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Feb. 23 1916

20. UNDERTAKER: T. C. Hudel — ADDRESS: C. D. A.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 13703
Registered No. 3

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d Alene
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marcus D Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1852 (Year)

7. AGE: 64 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: John W

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Mary Gibson

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S J Lyons
(Address) Rathdrum, Idaho

15. Filed Feb. 23 1916 M A Forland Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1914, to Feb 23 1916, that I last saw him alive on Feb 22 1916, and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Interstitial nephritis
.....
.....
(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration 3 yrs. ..... mos. ..... ds.

(Signed) S J Lyons M. D.
2-23 1916 (Address) Coeur d Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Spokane Wash
DATE OF BURIAL: Feb 26 1916

20. UNDERTAKER: S J Lyons
ADDRESS: Coeur d Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13704

Registered No. 6

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene (No. ....., ... St.)

Registration District No. 29

Primary Registration District No. 1050

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Caroline L. Hibbard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. March 14 1878 (Month) (Day) (Year)

7. AGE: 37 Yrs. 11 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Chris Butterfus

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles E Hibbard
(Address) Coeur d'Alene

15. Filed 2-26 1916. M. McDonald Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1902, to Feb. 1916, that I last saw her alive on Feb. 25 1916, and that death occured on the date stated above, at 1450 M.

The CAUSE OF DEATH* was as follows:

Multiple Sclerosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W Wynn M. D.

Feb 26 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Feb 27 1916

20. UNDERTAKER: J C Haddock — ADDRESS: C d A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13605

Registered No. ____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29

Primary Registration District No. 1050

(No. ____, ____ St.)

2. FULL NAME Paul A. Henry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. August 4 1888 (Month) (Day) (Year)

7. AGE: 28 Yrs. 7 Mos. ____ ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Paul A. Henry

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Armelda Taylor

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Armilda J. Henry

(Address) Coeur d'Alene Ida

15. Filed 2-29 1916 M. E. Bland Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 27 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1916, to Feb 26 1916, that I last saw h. m. alive on Jan 31 1916, and that death occured on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) J. C. Myers M. D.

Feb 28 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery | DATE OF BURIAL ____ 191__

20. UNDERTAKER: J. E. Hickey | ADDRESS C. D. A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 13206
Registered No. 8

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nellie Grace Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Dec. (Month) 27 (Day) 1893 (Year)

7. AGE
22 Yrs. 2 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) North Dakota

10. NAME OF FATHER: Geo. Evans

11. BIRTHPLACE OF FATHER
(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER: Fanny C. Felton

13. BIRTHPLACE OF MOTHER
(State or Country) Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. Evans
(Address) Coeur d'Alene

15. Filed Feb 29 1916 M. E. Roland Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
2 (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-24-1916, to 2-28-1916, that I last saw her alive on 2-26-1916, and that death occured on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Intestinal tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. E. Roland M. D.
2-29-1916 (Address) Cd Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Mch. 1 1916

20. UNDERTAKER: T. C. Heidel — ADDRESS: C. D. A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13507
Registered No. 46

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

2. FULL NAME Theresa Turner

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: about 75 years, but not known
(Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Georgia

10. NAME OF FATHER: J. Ford

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) paddy Taylor
(Address) Coeur D'Alene

15. Filed 2 — 1 — 1916 W. M. Colonel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 — 1 — 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10 1915, to Feb. 1st 1916, that I last saw h.. alive on Feb. 1st 1916, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Inflamatory stenosum.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Endocarditis
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Brunner M. D.
2-1 1916 (Address) Cd'Alene.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary | DATE OF BURIAL: Feb. 2 1916

20. UNDERTAKER: Cassedy & Nelson | ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13708

Registered No. 10

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....

2. FULL NAME Eliza Meddle.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	married

6. DATE OF BIRTH
..... 1 1842.
(Month) (Day) (Year)

7. AGE
74 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer.
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) U.S.

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Meddle
(Address) Orofino. Idaho.

15.
Filed Feby 20 1916 J. M. Tarey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb. 6 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26. 1916, to Feb. 6. 1916, that I last saw him alive on Feb. 5 1916, and that death occurred on the date stated above, at 3. a. M.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis.

..... (Duration) ? yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
..... (Duration) ? yrs. ..... mos. ..... ds.

(Signed) John Meddle M. D.
Feb 6 1916. (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 11 days. In the State ? yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? ?
Former or usual residence Idaho.

19. PLACE OF BURIAL OR REMOVAL: Troy Ida — DATE OF BURIAL: Feb 10 1916

20. UNDERTAKER: W. C. Stoddard — ADDRESS: Gifford Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13709

Registered No. 11

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Clearwater

City of Orofino

2. FULL NAME Maria Ellis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Sept (Month) 25 (Day) 1865. (Year)

7. AGE: 60. Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: Daniel Frost

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Ellis

(Address) Orofino - Idaho.

15. Filed Feb 20 1916 J. M. Stone Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12. 1915, to Feb. 7 1916, that I last saw h[illegible] alive on Feb. 7. 1916, and that death occured on the date stated above, at 7. P. M.

The CAUSE OF DEATH* was as follows:

Arterio - Sclerosis

(Duration) ' Yrs. ' mos. ' ds.

Contributory (Secondary) Insanity

(Duration) ' yrs. ' mos. ' ds.

(Signed) John Ellis M. D.

Feb 7 1916 (Address) Orofino. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 7. mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Idaho.

19. PLACE OF BURIAL OR REMOVAL: Spokane. Wash. DATE OF BURIAL: 2-11 1916

20. UNDERTAKER: J. Knight. ADDRESS: Spokane. Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No.
File No. 13710
Registered No. 12

1. PLACE OF DEATH.
County of Clearwater
City of Kiffe (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary E. Snyder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Feb (Month) 22 (Day) 1856 (Year)

7. AGE: 60 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Bowen

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samson Snyder
(Address) Drafus, Idaho

15.
Filed Feby 14 1916 J. M. Finley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 12 1916, to Feby 14 1916, that I last saw her alive on Feby 12 1916, and that death occurred on the date stated above, at 12.30 M.

The CAUSE OF DEATH* was as follows:

La Grippe

(Duration) 1 yrs. mos. ds.

Contributory (Secondary) Cancer of Liver

(Duration) 3 yrs. mos. ds.

(Signed) J. M. Finley M. D.
2/14 1916 (Address) Drafus, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fraser - Ida
DATE OF BURIAL: Feb 17 1916

20. UNDERTAKER: W. E. Stoddard
ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 13711
Registered No. 14

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leonie E. Overstreet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write proper word.): Married

6. DATE OF BIRTH. Sept (Month) 15 (Day) 1880 (Year)

7. AGE: 35 Yrs. 5 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): [illegible] Boise - Ida

10. NAME OF FATHER: Edward Conant

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Edella F Basie

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Philo Conant
(Address) Conant Ida

15. Filed Feb. 25th 1916. Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 7th 1916, to Feb. 25th 1916, that I last saw h[illegible] alive on Feb. 24th 1916, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Ventricular Heart Trouble.

(Duration) Several Yrs. mos. ds.
Contributory (Secondary) Acute Inf Rheumatism
(Duration yrs. mos. 18 ds.
(Signed) J. C. Patterson M. D.
2-25 1916 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Albion Ida — DATE OF BURIAL: 2/28 1916.

20. UNDERTAKER: Revewatt # 150 — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13712

Registered No. 115

1. PLACE OF DEATH.

County of Cassia

City of Burley Ida.

Registration District No. 117

Primary Registration District No. 2196.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oline Haycock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Jany (Day) 9 (Year) 1893

7. AGE: 23 Yrs. 1 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Myron Higley

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Jeanette Miles

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Dawson Haycock Jr.
(Address) .....

15. Filed Feb. 23rd 1916 Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) July (Day) 22nd 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 15th 1916, to July. 22nd 1916, that I last saw h.r alive on Feb. 22nd 1916, and that death occured on the date stated above, at 9p M.

The CAUSE OF DEATH* was as follows:
Pelvic Cellulitis

.....(Duration) ..... Yrs. ..... mos. 28 ds.

Contributory (Secondary) Placenta Praevia Centralis

.....(Duration ..... yrs. 7 mos. ..... ds.

(Signed) J. C. Patterson M. D.

2-25 1916 (Address) Burley, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elba - Ida — DATE OF BURIAL: July 23 1916

20. UNDERTAKER: Rowell — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 1373
Registered No. 13

1. PLACE OF DEATH.
County of Blaine.
City of Bellevue.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo. N. Laughlin.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: Wht.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Mar. (Month) 13 (Day) 1840 (Year)

7. AGE: 75 Yrs. 10 Mos. 28 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. P. Bryden
(Address) Bellevue

15. Filed Feb 13 1916 Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1916, to Feb 10 1916, that I last saw h—alive on Feb 10 1916, and that death occured on the date stated above, at 3:40 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Bright's disease
Uremic poisoning

(Duration) unknown Yrs. mos. ds.
Contributory (Secondary): Senility
(Duration yrs. mos. ds.

(Signed) A. E. Bryden M. D.
3/10 1916. (Address) Bellevue Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellevue — DATE OF BURIAL: Feb 12 1916

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13714
Registered No. 26

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9c
Primary Registration District No. 1009
(No. 535, Lynnhaven Ave., St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Chester Patten

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~

6. DATE OF BIRTH: Nov. 29th 1915
(Month) (Day) (Year)

7. AGE: — yrs. 2 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Baby
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston, Ida.

10. NAME OF FATHER: Edward Patten

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Elma Needham

13. BIRTHPLACE OF MOTHER (State or Country): Roseburg Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Patten.
(Address) Lewiston, Ida.

15.
Filed 3-10- 1916 L. G. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 6th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191—, to — 191—
that I last saw h— alive on — 191—,
and that death occurred on the date stated above, at about 3 A. M.

The CAUSE OF DEATH* was as follows:
Accidental
Scalding.
of
(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) F. P. Haun M. D.
2/6/1916 (Address) Lewiston.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: 7th Feb. 1916

20. UNDERTAKER: C. J. Varran
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13715
Registered No. 27

1. PLACE OF DEATH.

County of Nez Perce
City of Lewiston
(No. North Idaho Home & Aid St.)
Sweety Home.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1009

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Billy Kavanaugh.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	White	

6. DATE OF BIRTH. Jan. (Month) 2 (Day) 1916 (Year)

7. AGE ....Yrs. 29 Mos. ....ds. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER Wm Kavanaugh

11. BIRTHPLACE OF FATHER (State or Country) Gilbert Idaho.

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary J. Chase Asst
(Address) C. Childrens Home

15. Filed 3-10- 1916 L.J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 31 1916, to Jan 31 1916, that I last saw him alive on Jan. 31 1916, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Inanition.
(Duration) — Yrs. — mos. 14 ds.
Contributory (Secondary) Acute indigestion
(Duration — yrs. — mos. — ds.

(Signed) L.J. Perkins M. D.
2/1 1916 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Lewiston — DATE OF BURIAL 2/2 1916

20. UNDERTAKER L.J. Carson — ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & RDRS. 24659

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 13716
Registered No. 20

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 13th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard D Calvert.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Nov. (Month) 25 (Day) 1844 (Year)

7. AGE 71 Yrs. 2 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired Stock Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Howard Co. Mo.

10. NAME OF FATHER Martin Calvert

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Mary Rawlins

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. D Calvert
(Address) 848½ Main, Lewiston

15. Filed Feb 11 1916 L.J. Perkins Local Registrar
3-10-1916

SYMS - YORK CO., PTRS. & BOKS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on Feb. 10 1916,
and that death occured on the date stated above, at 9.50 P.M.
The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) — Yrs. — mos. 3 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L.J. Perkins M. D.
2/11 1916 (Address) L.J. Perkins

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston — DATE OF BURIAL 2/13 1916

20. UNDERTAKER L. Lassar — ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13717

Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9

Primary Registration District No. 1009

(No. ..... Hospital St.)

2. FULL NAME Martha F Foster

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 65 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister M. Borgia

(Address) Lewiston Ida

15. Filed 3-10- 191 6

L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 9th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1916, to Feb 9th 1916, that I last saw h[illegible] alive on Feb 9th 1916, and that death occured on the date stated above, at 11:15 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. 3 1 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 3/11 1916

20. UNDERTAKER: [signature] — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. I-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 1318
Registered No. 22

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Marion Rowden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Dec. (Month) 1 (Day) 1876 (Year)
7. AGE: 39 Yrs. 2 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Missouri
10. NAME OF FATHER: Isaac Rowden
11. BIRTHPLACE OF FATHER (State or Country): —
12. MAIDEN NAME OF MOTHER: Caroline Clark
13. BIRTHPLACE OF MOTHER (State or Country): —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. F. M. Rowden
(Address) Asotin Wash.
15. Filed 3-10-1916 L. G. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 7, (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from February, 3, 1916, to February 7, 1916, that I last saw him alive on February, 7, 1916, and that death occured on the date stated above, at 9.15P M.
The CAUSE OF DEATH* was as follows:

Acute Peritonitis.

(Duration) ### Yrs. ### mos. 1 ds.
Contributory (Secondary) Acute Purulent Appendicitis.
(Duration ### yrs. ### mos. 5 ds.
8 (Signed) [illegible] M. D.
February 19 16 (Address) Asotin, Washington.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Asotin Wash. DATE OF BURIAL: Feby 10 1916
20. UNDERTAKER: H. C. Merchant ADDRESS: Asotin Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9E
Primary Registration District No. 1009
(No. .... St.)

File No. 13719
Registered No. 23

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fannie Bentley Billow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Nov (Month) 20 (Day) 1867 (Year)

7. AGE: 48 Yrs. 3 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Seth Bentley

11. BIRTHPLACE OF FATHER (State or Country): X X

12. MAIDEN NAME OF MOTHER: Mary L. Green

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Crumpton Flowers
(Address) Clarkston Wash.

15. Filed 3-10- 1916 L. J. Perkins Local Registrar

BYRNS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1915, to Feb 29 1916, that I last saw her alive on Feb 27 1916, and that death occured on the date stated above, at 5.30 M.

The CAUSE OF DEATH* was as follows: Carcinoma, metastatic breast, + abdominal

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) .....
(Duration ..... yrs. mos. ds.

(Signed) D. H. Ransom M. D.
2/24 1916 (Address) Clarkston.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 14 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Wash.
Former or usual residence Clarkston Wash

19. PLACE OF BURIAL OR REMOVAL: [illegible] Cemetery — DATE OF BURIAL: 3/ 1916

20. UNDERTAKER Clarkston Wash H. R. Merchant — ADDRESS Clarkston Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 320 6th Ave. St.)
Registration District No. 96
Primary Registration District No. 1009
File No. 13720
Registered No. 94
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Belle Longbrake

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 16 (Day) 1871 (Year)

7. AGE: 43 Yrs. 2 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: O. A. Barto

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Sarah Tillinghame

13. BIRTHPLACE OF MOTHER (State or Country): England, London

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elizabeth Longbrake
(Address) 600 6th Ave Lewiston Ida

15. Filed 3-10- 1916 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw her alive on Feb 4 1916,
and that death occured on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia.

(Duration) — Yrs. — mos. 20 ds.
Contributory (Secondary) Bronchitis
(Duration Sundays) ..... yrs. ..... mos. ..... ds.
(Signed) L. J. Perkins M. D.
2/6 1916 (Address) Lewiston Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Chicago Ill — DATE OF BURIAL: 2/8 1916

20. UNDERTAKER: R. Glassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTR. & STNR. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 6009
File No. 13721
Registered No. 25

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 1115 Gorby St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rhoda Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. May (Month) 12 (Day) 1 (Year)

7. AGE: 19 Yrs. 7 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: scholar
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Wm A Wright

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Florence Roney

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Florence M Wright
(Address) Lewiston Idaho

15. Filed 3-10- 1916 L G Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Feb (Month) 26th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13th 1916, to Nov 8 - 1916, that I last saw her alive on Feb 25th 1916, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) R. G. Larason M. D.
Feb 27th 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 3/27 1916

20. UNDERTAKER: R G Larason — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9c
Primary Registration District No. 1009
File No. 13722
Registered No. 1

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant John Leetch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. (Month) 2 (Day) 10 (Year) 16
7. AGE: ____ Yrs. ____ Mos. 6 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Lewiston
10. NAME OF FATHER: John Leetch
11. BIRTHPLACE OF FATHER (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: L. M. Harwood
13. BIRTHPLACE OF MOTHER (State or Country): Ill.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J Leetch
(Address) 1454 Idaho St
15. Filed 3-10- 1916 L J Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Feb. (Day) 16 1916
17. I HEREBY CERTIFY, That I attended deceased from 191__, to 191__, that I last saw he alive on Feb. 16 1916 and that death occured on the date stated above, at 8:30 P.M.
The CAUSE OF DEATH* was as follows:
Anaemia
(Duration) Yrs. mos. 6 ds.
Contributory (Secondary) Premature birth
(Duration yrs. mos. ds.
(Signed) L. J. Parker M. D.
2/17 1916 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. 6 days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida. DATE OF BURIAL 191__
20. UNDERTAKER: L. L. Sasser ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BKBS. 24658

continuing

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 13724
Registered No. 96

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 622 Main St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Adda E. Hirsch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	married

6. DATE OF BIRTH. Dec (Month) 6 (Day) 1884 (Year)

7. AGE 31 Yrs. 2 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife,
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Samuel Stevens

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Walter Hirsch
(Address) Lewiston Ida.

15. Filed 3-10-1916 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
2 (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7th 1916, to Feb. 13-1916, that I last saw h[er] alive on Feb 10-1916 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pneumonia to Nephritis (Chronic)
(Duration) 1 Yrs. 3 mos. ..... ds.
Contributory (Secondary) Influenza,
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. P. Hayes, M. D.
2/16 1916 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida. DATE OF BURIAL: 2/17 1916

20. UNDERTAKER J. Larson ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & BKRS. 94658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 13725
Registered No. 17

1. PLACE OF DEATH.
County of Nezperce
City of Lewiston
(No. 1709 6th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Huffman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Man
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. June 17 (Month) 1831 (Day) 1 (Year)

7. AGE: 84 Yrs. 8 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pensylvania Bedford Co

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mrs Hettie Kreig
(Address): Lewiston Idaho

15. Filed 3-10-1916 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-18 1916, to Feb. 23 1916, that I last saw h.. alive on 2-18 1916, and that death occured on the date stated above, at 7 a. M.

The CAUSE OF DEATH* was as follows:
Old age
Senility
(Duration) many Yrs. mos. ds.
Contributory (Secondary) Cerebral dropsy.
(Duration Yrs. mos. ds.

(Signed) L. J. Perkins M. D.
2/22 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 2/24 1916

20. UNDERTAKER: L. J. Wasson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

STAR - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13726

Registered No. 18

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

(No. 1027, 9th Ave St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm H. Hayes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 1 (Day) 1870 (Year)

7. AGE: 45 Yrs. 7 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N York

10. NAME OF FATHER: Henry Hayes

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Bridget Murrey

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Lale Manner

(Address): Lewiston

15.

Filed 3-10- 1916

L J Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1 1914, to Feb 22 1916, that I last saw h[illegible] alive on Feb. 21 1916, and that death occured on the date stated above, at 6 a M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitant.

(Duration) 2 Yrs. - mos. - ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L J Perkins M. D.

2/23 1916 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: 2/22 1916

20. UNDERTAKER: L Carson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13727
Registered No.

1. PLACE OF DEATH.
County of Franklin
City of Weston (No. , Heber St.)
Registration District No.
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph J. McKay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 14 (Day) 1914 (Year)

7. AGE: 1 yrs. 8 mos. 20 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ogden Utah

10. NAME OF FATHER: Heber J. McKay

11. BIRTHPLACE OF FATHER (State or Country): Hyattville Weber Co. Utah

12. MAIDEN NAME OF MOTHER: Mabel Barton

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Heber J. McKay
(Address) Weston, Idaho

15.
Filed 191
Wesley F. Fuller
Clerk Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 25th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23rd 1916, to Jan 25th 1916, that I last saw him alive on Jan. 23rd 1916, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH was as follows:
Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

Contributory (Secondary)
(Duration) yrs. mos. 4 ds.

(Signed) T. B. Budge M. D.
Jan 28th 1916 (Address) Logan Utah

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: Jan 31 1916

20. UNDERTAKER: C. A. Lundquist — ADDRESS: Logan Utah

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 13728
Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Franklin
City of Preston RF.D.#2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Humphrey Winn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Jan. (Month) 5 (Day) 1861 (Year)

7. AGE: 55 Yrs. 1 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Toole Co Utah

10. NAME OF FATHER: Josiah Brower

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Jane Humphrey

13. BIRTHPLACE OF MOTHER (State or Country): Toronto, Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J M Winn
(Address) .....

15. Filed 3/10 1916 D A R Butler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1916, to Feb. 5 1916, that I last saw her alive on Feb. 5, 1916, and that death occured on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
(Duration) Yrs. 3 mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Bland M. D.
2/19, 1916. (Address) Preston, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: N. A. Skidmore per A. A. Monson
ADDRESS

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ..... St.)

File No. 13729
Registered No. 5
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Z Moore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH Do not know 1
(Month) (Day) (Year)

7. AGE 67 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER John C Moore

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER [illegible]

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Feb 20 1916 Edith D Kendall Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
..... 191...
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 1915, to Feb 13th 1916, that I last saw h[illegible] alive on Feb 13th 1916, and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Chronic Bright's disease

..... (Duration) — yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) — yrs. — mos. — ds.

(Signed) F. S. Wright M. D.
2/20 1916 (Address) Salmon.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
[illegible]	[illegible] 191...

20. UNDERTAKER	ADDRESS
[illegible]	[illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Palouse
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ——, ——— St.)

File No. 13730
Registered No. 4
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Domenico Barsaglio

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH
——— (Month) ——— (Day) 1 (Year)

7. AGE
56 yrs. ——— mos. ——— ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F J Wright
(Address) Palouse

15.
Filed Feb. 21 1916 Edith O Henderson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 20th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 1st 1916, to Feb 20 1916, that I last saw h— alive on Feb 20 1916, and that death occurred on the date stated above, at 11.55 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) — yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) F. J. Wright M. D.

Feb 21 1916 (Address) Palouse

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Palouse Cemetery	2-21st 1916
20. UNDERTAKER	**ADDRESS**
W C Hoeble	Palouse Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13731

Registered No. 29

1. PLACE OF DEATH.

County of Bonner

City of .....

(No. ....., ... St.)

Registration District No 81

Primary Registration District No 2158

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Maio

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Oct (Month) 15 (Day) 1846 (Year)

7. AGE: 69 Yrs. 3 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer Common

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Frank Maio

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Anna Maccaratto

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Anselmo

(Address) Priest River

15. Filed Feb 5 1916 E S McCarty Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1915, to Feb 5 1916, that I last saw h[illegible] alive on August 1915, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation
arterio Sclerosis
General ascites

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Myocarditis Chron. Endocarditis

(Duration) ? yrs. ..... mos. ..... ds.

(Signed) E S McCarty M. D.

2/5 1916 (Address) Priest River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Priest River — DATE OF BURIAL: Feb 7 1916

20. UNDERTAKER: J Edward Furst — ADDRESS: Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 81

Primary Registration District No. 2158

File No. 13732

County of Bonner

City of Priest River (No. ....., ... St.)

Registered No. 90

If death occurred away from usual residence, give facts called for under special information.

2. FULL NAME, Nodmand John Eastland

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (write word)
Male	White	don't know

6. DATE OF BIRTH Don't Know
(Month) (Day) (Year)

7. AGE about 48 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Homesteader
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Swan Unger
(Address) Nodmand Idaho

15. Filed Feb 12 1916 E. McCarty Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Suicide about Feb "12" 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Gun shot Wound 32 Winchester Rifle Entering Neck and breaking neck
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W H Knapp Coroner M. D.
Feb 14 1916 (Address) Hope Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Priest River | DATE OF BURIAL Feb 13 1916

20. UNDERTAKER J. F. Fust | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
(No. ..... St.)
Registration District No. 16
Primary Registration District No. 1016
File No. 13734
Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lewis C. Patterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~: Single (Write the word.)

6. DATE OF BIRTH. unknown
X (Month) X (Day) 1 X (Year)

7. AGE: about 52 Yrs. X Mos. X ds.
IF LESS than 1 day how many X hrs. or X min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Farm-Land

9. BIRTHPLACE (State or Country): unknown X

10. NAME OF FATHER: unknown X

11. BIRTHPLACE OF FATHER (State or Country): unknown X

12. MAIDEN NAME OF MOTHER: unknown X

13. BIRTHPLACE OF MOTHER (State or Country): unknown X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) From letters and Identification card.
(Address) ⊗

15. Filed Mch 28 1916
J. L. Turner
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 15 1915, to March 24 1916, that I last saw h. alive on March 24 1916, and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation, Cardiac Dilatation

(Duration) Several Yrs. mos. ds.
Contributory (Secondary): Secondary Nephritis
(Duration yrs. mos. ds.

(Signed) Chas. T. Keller M. D.
3/24 1916 (Address) Shoshone, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: 3/28 1916

20. UNDERTAKER: O. J. Brennan — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYRE - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2016
File No. 18735
Registered No. .....

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kenneth K Dale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept 18 1889 (Month) (Day) (Year)

7. AGE: Yrs. 26 Mos. 5 ds. 18 — IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Kittel Dale

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: K Z E Rstii Lorte

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas K Dale
(Address) .....

15. Filed Mch 12 1916 — J L Sullen, Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1916, to March 10 1916, that I last saw him alive on March 10 1916, and that death occured on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:
Tubercular Pneumonia
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas F Feller M. D.
3/14 1916 (Address) Shoshone, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: 3/14 1916

20. UNDERTAKER: O J Brennan — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 13736
Registered No. 13

1. PLACE OF DEATH.
County of Ada
City of near Boise
(No. near Franklin School)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Erma Celevine Brocow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 27 (Day) 1913 (Year)

7. AGE: ... Yrs. 2 Mos. 10 ds.
IF LESS than 1 day how many ... hrs. or ... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: G. A Brown

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Elsie Dittmars

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George A. Brown
(Address) Gen Del Boise Idaho

15. Filed March 8 1916
E. J. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 7th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6th 1916, to March 7th 1916, that I last saw h[illegible] alive on March 7th 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Whooping cough
(Duration) yrs. mos. ds.
(Signed) John Barr M. D.
3-8 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: Mar 8 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & STRS. 24653

Ada

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13737

Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of near Boise

Registration District No. 8

Primary Registration District No. 2004

(No. 24 th & Anderson St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arlie Froman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): divorced

6. DATE OF BIRTH. Not Obtainable (Month) (Day) 1840 (Year)

7. AGE: 76 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not Obtainable

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable.

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter D Cole

(Address) 214 Anderson

15. Filed 3/11 1916

E. H. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1915, to March 11 1916, that I last saw her alive on March 11 1916, and that death occured on the date stated above, at 11.30 P.M.

The CAUSE OF DEATH* was as follows:

morphinism—chronic

(Duration) 40 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Maurice Fallemon M. D.

3/13 1916. (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 13 1916

20. UNDERTAKER: Frey & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH 8

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13738

Registered No. 15

1. PLACE OF DEATH.

County of Ada.

City of Near Boise

Primary Registration District No. 2004

(No. Gary Station St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Cox.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M.	White	Widower (Write one word)

6. DATE OF BIRTH. May 6 1827
(Month) (Day) (Year)

7. AGE 88 Yrs. 10 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio.

10. NAME OF FATHER Lauren Cox

11. BIRTHPLACE OF FATHER (State or Country) Maryland.

12. MAIDEN NAME OF MOTHER Nellie Carey.

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jennie H Casey

(Address) .....

15. Filed 3/18 1916

E. J. Caton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 17th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st 1916 to March 17th 1916, that I last saw him alive on March 15 1916 and that death occured on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Cyoplexy —

(Duration) ..... Yrs. ..... mos. 17 ds.

Contributory (Secondary) Pneumonia complicating

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John Burk M. D.

3-17 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain Home Ida	Mar 18 1916

20. UNDERTAKER	ADDRESS
Fry & Summers	Boise.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

File No. 13739

Registered No. 16

County of Ada

City of 6 Miles West of Boise City. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Liza J. Coble

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Dec 22nd (Month) (Day) 1837 (Year)

7. AGE: 78 Yrs. 4 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: John Roselle

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Coble

(Address) Eagle, Idaho

15. Filed March 22, 1916

E. J. Slater
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 21st (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 20 1916, to Mch 21 1916, that I last saw h[illegible] alive on Mar 21 1916, and that death occured on the date stated above, at 2:40 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular

(Duration) ..... Yrs. ..... mos. — ds.

Contributory (Secondary) Influenza

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) W. F. Kinkaid M. D.

3/22/16 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Ada County, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 3/23 1916

20. UNDERTAKER: Schreiber & Siddenfaden | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Dr. Turkey

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

File No. 13740

Registered No. 17

County of Ada

City of B

(No. Idaho State Penitentiary)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred Crayton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, ~~MARRIED~~, ~~WIDOWED OR DIVORCED~~. (Write the word.)
Male	Negro	

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE about 44 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Convict
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Leavenworth, Kansas

10. NAME OF FATHER Madison Crayton

11. BIRTHPLACE OF FATHER (State or Country) Not ottainable

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F E Walker
(Address) Boise, Ida

15. Filed March 27th, 1916 E. H. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 26 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. Collum M. D.

..... 19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 10 yrs. 3 mos. 18 days. In the State Ida. ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? State

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pendleton Kansas — DATE OF BURIAL: 3/28/1916

20. UNDERTAKER: Schreiber & Mollenbrock — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 13741
Registered No. 18

1. PLACE OF DEATH.
County of Ada
City of —
If death occurs away from usual residence, give facts called for under special information.
(No. near Black Creek St.)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Viola Eunice Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: Mar 16th 1853 (Month) (Day) (Year)

7. AGE: 63 yrs. — mos. 10 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: George Baker

11. BIRTHPLACE OF FATHER (State or Country): R. I.

12. MAIDEN NAME OF MOTHER: Mary Lawton

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Marcellus
(Address) Regina Ida

15. Filed 3/27 1916 E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar 26th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5th 1916 to Mar 26 1916, that I last saw h— alive on — 1916, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) Epilepsy

(Duration) 12 yrs. — mos. — ds.

(Signed) J. A. Sprunger M. D.

Mar 26 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 3/28 1916

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 8

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13742

Registered No. 10

1. PLACE OF DEATH.

County of Ada

City of Meridian (No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank W Joy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. May (Month) 11 (Day) 1833 (Year)

7. AGE: 82 Yrs. 9 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Horseman
(b) General nature of industry, business, or establishment in which employed (or employer): ———

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Moses Joy.

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. E. Parsons
(Address) Soldiers' Home

15. Filed March 6th, 1916

E. H. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/1 1915, to 3/4 1916, that I last saw h.. alive on 3/2 1916, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. A. Tuttle M. D.

3/4 1916 (Address) Idaho Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem.

DATE OF BURIAL: Mch 6 1916

20. UNDERTAKER: Fry & Summers Co.

ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVING - YORK CO., PTRS. & ADDS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13743

Registered No. 11

1. PLACE OF DEATH.

County of Ada.

City of Boise

(No. Soldiers Home. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sanford A. Herendeen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. — (Month) — (Day) 1/1842 (Year)

7. AGE: 71 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Massachusetts.

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. H. Brainard
(Address) Soldiers' Home

15. Filed Mar 6th, 1916 — E. H. Eaton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — 3 (Month) — 6 (Day) — 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1915, to 3-3 1916 that I last saw h[illegible] alive on 3/4 1916, and that death occured on the date stated above, at 11:45 M.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred W. Jeffreys M. D.

3/6 1916 (Address) Soldiers Home Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. — DATE OF BURIAL: Mar 6 1916

20. UNDERTAKER: Frye & Summers Co. — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13744 12

Registered No. .....

1. PLACE OF DEATH.

County of Ada

City of Near Boise (No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Noah W. Brooks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Not Obtainable (Month) 1845 (Year)

7. AGE: 71 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. G. Burnett

(Address) Soldiers Home

15. Filed March 8th, 1916

E. F. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1915, to 3/8 1916, that I last saw h[illegible] alive on 3/7 1916, and that death occured on the date stated above, at 6A M.

The CAUSE OF DEATH* was as follows:

Acute Erysipelas

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Interstitial Nephritis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred A Bonney M. D.

3/8 1916 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: May 9 1916

20. UNDERTAKER: Frey & Summers — ADDRESS: Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13746

Registered No. 80

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No.

Primary Registration District No. 1002

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lillian Carroll

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 6 (Day) 1872 (Year)

7. AGE: 43 Yrs. 3 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wy.

10. NAME OF FATHER: Donald Mc Phee

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Catherine Mc Cechnie

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Carroll

(Address) Boise

15. Filed 3/27 191 6

E. J. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18 1916, to 3-25 1916, that I last saw h-er alive on 3-25 1916, and that death occured on the date stated above, at 12a M.

The CAUSE OF DEATH* was as follows:

Uremic retrogression

Mitral stenosis.

(Duration) Duration Yrs. mos. ds.

Contributory (Secondary) Ulcer stomach

(Duration yrs. Duration mos. ds.

(Signed) W. S. Eyton M. D.

3-27 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence ..... Wyoming

19. PLACE OF BURIAL OR REMOVAL: Cheyenne Wy. DATE OF BURIAL: April 3 1916

20. UNDERTAKER: Schreiber & Lidenfelter ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 13747 / 79

Registered No.

County of Ada

City of Boise (No. 710, Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Tom Hung

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: about (Month) (Day) 1856 (Year)

7. AGE: about 60 yrs. mos. ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: not obtainable

11. BIRTHPLACE OF FATHER (State or Country): not obtainable

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chinese Lee
(Address)

15. Filed 3/25 1916 E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 24th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13th 1916, to March 27th 1916, that I last saw h[illegible] alive on March 13th 1916 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) 1 yrs. mos. ds.

(Signed) John Baer M. D.

3-27 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos...days. In the State ...yrs...mos...days.

Where was disease contracted if not at place of death?

Former or usual residence: Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Chinese Cemetery — DATE OF BURIAL: 3/27 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13749

Registered No. .....

Registration District No. .....

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Willa Ruth McChesney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan 1 (Month) 1 (Day) 1895 (Year)

7. AGE: 21 Yrs. 2 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: William H. Geiger

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Frankie Porter.

13. BIRTHPLACE OF MOTHER (State or Country): Maine.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lee McChesney

(Address) 709 No. 21st. City

15. Filed 3/20 1916 E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1916, to March 20 1916, that I last saw h[illegible] alive on March 19 1916, and that death occured on the date stated above, at 6 20a M.

The CAUSE OF DEATH* was as follows:

Pyelonephritis due to streptococcus

(Duration) Yrs. 2 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Maurice Fallon M. D.

3/20 1916 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Mar 21 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13750 / 76

Registration District No. 2

Primary Registration District No. 1004

Registered No. .....

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 109 So 15th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert J. Stewart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. November 14th 1859 (Month) (Day) (Year)

7. AGE: 56 Yrs. 4 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Talbert Co, Md.

10. NAME OF FATHER: Perry W Stewart

11. BIRTHPLACE OF FATHER (State or Country): Md.

12. MAIDEN NAME OF MOTHER: Eliza Maloney

13. BIRTHPLACE OF MOTHER (State or Country): Md

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Fanny F Stewart

(Address) Boise, Idaho

15. Filed 3/16 1916 E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1915, to Mar 15 1916, that I last saw h. alive on Mar 15 1916, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. — mos. ..... ds.

(Signed) Fred A Dieng er M. D.

3/15 1916 (Address) Fred Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Newport News, Va.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 3/17 1916

20. UNDERTAKER: Schreiber & Siedenfaden — ADDRESS: Boise,

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13751

Registered No. 75

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 10 4

County of Ada

City of Boise (No. 703 Thatcher St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Davis Flemmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: February (Month) 8 (Day) 1851 (Year)

7. AGE: 65 yrs. 1 mos. 6 ds.

IF LESS than 1 day how many .....*hrs. or* .....*mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Writer

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Daniel Flemmer

11. BIRTHPLACE OF FATHER (State or Country) America

12. MAIDEN NAME OF MOTHER Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country) America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Reginald G. Flemmer
(Address) 1111 N. 5th St.

15. Filed 3/15 1916 E. J. Peters Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 7 1916, to Mch 14 1916, that I last saw h alive on Mch 14 1916 and that death occurred on the date stated above, at 7A M.

The CAUSE OF DEATH* was as follows:

Diabetic coma

.....(Duration) .....yrs. .....mos. .....ds.

Contributory Diabetes

(Secondary)

.....(Duration) 3 yrs. .....mos. .....ds.

(Signed) Jos. L. Flemmer M. D.

3/16 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 3/16 1916

20. UNDERTAKER: Schreiber & Lidenfelser — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13752

Registered No. 74

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 811 Thatcher St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Catherine Faust

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH. DEC (Month) 23 (Day) 1859 (Year)

7. AGE: 66 Yrs. ..... Mos. 2 ds. 20

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): U S A

10. NAME OF FATHER: Woodman

11. BIRTHPLACE OF FATHER (State or Country): U S A

12. MAIDEN NAME OF MOTHER: Glascow

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. A. Faust

(Address) 1011 N 8 Boise

15. Filed 3/14 1916

C. F. Cotton
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1916, to March 12 1916, that I last saw h[illegible] alive on March 14 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Asthma Cardiac

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Thos. Cathcart M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake Utah — DATE OF BURIAL: 3/15 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 1003, Bank St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004

File No. 13753
Registered No. 75
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur E. Pulford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: August (Month) 10 (Day) 1884 (Year)

7. AGE: 31 yrs. 7 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mont.

10. NAME OF FATHER: Frank L. Pulford

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: M. J. Cudney

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M J Kissle
(Address)

15. Filed 3/15 1916 E A Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1915, to March 14 1916, that I last saw h[illegible] alive on March 14 1916 and that death occurred on the date stated above, at 11 24 M.

The CAUSE OF DEATH* was as follows:
Brain tumor
Cystic tumor in right temporo sphenoidal lobe
(Duration) 2 yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. H. Falconer M. D.
3/14 1916 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence: Brownsville Shipment

19. PLACE OF ~~BURIAL OR REMOVAL~~: Portland Oregon
DATE OF BURIAL: Mch 18 1916

20. UNDERTAKER: Schreiber & Redemptorists
ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 1004
File No. 13754
Registered No. 72

1. PLACE OF DEATH.
County of Ada.
City of So Boise.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jesse A. Rambo.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married.
6. DATE OF BIRTH: May 27 1
(Month) (Day) (Year)
7. AGE: 57 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Missouri
10. NAME OF FATHER: George Rambo.
11. BIRTHPLACE OF FATHER (State or Country): Ohio.
12. MAIDEN NAME OF MOTHER: Louisa Swisher.
13. BIRTHPLACE OF MOTHER (State or Country): Ohio.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Jesse C Rambo
(Address) .....
15. Filed 3/8 191 6
E. J. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 7 191 6
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 4 191 6, to March 7 191 6, that I last saw h— alive on 7 March 191 6 and that death occured on the date stated above, at 11.30 M.
The CAUSE OF DEATH* was as follows:
Cardiac
(Duration) 20 Yrs. mos. ds.
Contributory (Secondary) Valvular Heart disease
(Duration) 20 yrs. mos. ds.
(Signed) R E Lantz M. D.
3/7 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Star Idaho. DATE OF BURIAL: March 9 1916
20. UNDERTAKER: Frye Summers ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

EVANS - YORK CO., PTRS. & STRS. 24953

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 13755
Registered No. 71

1. PLACE OF DEATH.
County of Ada.
City of Boise.
(No. 1702 Ave B. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward H. Hulser.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M.	White	Married (or Wid.)

6. DATE OF BIRTH. Sep (Month) 30 (Day) 879 (Year)

7. AGE 36 Yrs. 5 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Attorney.
(b) General nature of industry, business, or establishment in which employed (or employer)... —

9. BIRTHPLACE (State or Country) Iowa.

10. NAME OF FATHER Geo Hulser.

11. BIRTHPLACE OF FATHER (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Myra Hawkins.

13. BIRTHPLACE OF MOTHER (State or Country) New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G F Hulser
(Address)

15. Filed 3/8 191 6
E J Cutts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1915, to Mar 7 1916, that I last saw him alive on Mar 7 1916, and that death occured on the date stated above, at 11.20 P. M.

The CAUSE OF DEATH* was as follows:
Septicemia (Micrococcus tetragens) and Anaemia.

(Duration) 1 Yrs. 6 mos. ds.
Contributory (Secondary) Pulmonary oedema.
(Duration yrs. mos. 1 ds.

(Signed) H. N. Braptan M. D.
Mar 8 1916 (Address) Empire Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill.	Mar 9 1916
20. UNDERTAKER	**ADDRESS**
Fry & Summers.	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STMS - YORK CO., PTRS. & STRS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 13756
Registered No. 70

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 410, State St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Illeres

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE: About 65 Yrs. yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Land Owner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Schleswig Holstein Germany

10. NAME OF FATHER: [illegible]

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Fassbender
(Address) Boise Idaho

15. Filed 3/7 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: [illegible] (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3 1916, to March 5 1916, that I last saw him alive on March 5 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Acute Rheumatism

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
19 .... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 3/12 1916

20. UNDERTAKER: Schreiber & Sedgwick — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13757

Registered No. 69

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 110 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida M Anderson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sep (Month) 12 (Day) 1 (Year)

7. AGE 40 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: P. J Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Margretta Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H Anderson
(Address) .....

15. Filed 3/5 191 6

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st 1916, to March 3rd 1916, that I last saw h 22 alive on March 3 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
acute dilatation of heart
two days after removal
of Gall Stones.
(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Gall Stones
(Duration 6 yrs. ..... mos. ..... ds.

(Signed) L. R. Medlin M. D.
3/4/16 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: Mch 6 1916

20. UNDERTAKER: Foy & Summers. — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 13758

Registered No. 68

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada.

City of Boise

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara I Ingard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Mar (Month) 2 (Day) 1861 (Year)

7. AGE: 55 Yrs. 7 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Mathew Moody

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Tagon

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A W Moody

(Address) Vancouver Wash

15.

Filed 3/5 1916

C E Colton
Local Registrar

SVMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mch. (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1916, to March 8 1916, that I last saw h e alive on March 3rd 1916, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pyelonephritis, with Endotoxis of veins in legs etc

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Fibroid of uterus

(Duration 2 yrs. ..... mos. ..... ds.

(Signed) L. P. McCall M. D.

3/4 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho.

DATE OF BURIAL 191

20. UNDERTAKER: Gray & Summers Co.

ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1904
File No. 13759
Registered No. 67

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1518 N 20 St. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph C. Thrailkill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH.
Feb 14 (Month) (Day) 1840 (Year)

7. AGE
76 Yrs. ____ Mos. 18 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Mo

10. NAME OF FATHER Jacob Thrailkill

11. BIRTHPLACE OF FATHER (State or Country) Kentucky.

12. MAIDEN NAME OF MOTHER Eleanor Knoy

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. W. Thrailkill
(Address) Boise, Idaho.

15.
Filed 3/4 19 16
C. F. Cutts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1916, to Mar 2 1916, that I last saw him alive on Mar 2 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Rectum
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Intestinal obstruction
(Duration yrs. mos. 4 ds.
(Signed) Thomas N. Brattan M. D.
Mar 3 1916. (Address) Empire Bldg. Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hillcrest DATE OF BURIAL: Mar 3 1916

20. UNDERTAKER: Frey & Summers ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V[illegible]. 5-25 M. 1-16-13

36984

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13760

Registered No. 66

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada.

City of Boise.

(No. 2473 Ada. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Winfield S. Waters.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 13 (Day) 1847 (Year)

7. AGE: 69 Yrs. 1 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): ———

9. BIRTHPLACE (State or Country): Indiana.

10. NAME OF FATHER: Samuel Waters.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Mary Ketchum

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Waters

(Address) /

15. Filed 3/I 1916

E. V. Cutin
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1916 to March 1 1916, that I last saw h[illegible] alive on Feb 29 1916 and that death occured on the date stated above, at 30a M.

The CAUSE OF DEATH* was as follows:

General paresis

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) W. H. Coleman M. D.

3/1 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: March 2 1916

20. UNDERTAKER: Foy & Summers ADDRESS: Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 36
County of Twin Falls Primary Registration District No.
City of Kimberly (No. , St.)
File No. 13761
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eva Alice Tilley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mar 22 1916 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Harold A Tilley

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Eula F. Hartley

13. BIRTHPLACE OF MOTHER (State or Country): N. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. O. F. Hartley
(Address) Kimberly Idaho

15. Filed Mar 28 1916 J. M. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar 26 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 22 1916, to Mar 26 1916
that I last saw him alive on Mar 24 1916
and that death occurred on the date stated above, at 10 a.m.
The CAUSE OF DEATH* was as follows:
Icterus neonatorum
of Sudden Disappearance was only Symptom, death with
2 hrs. (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Davis M. D.
3-26 1916 (Address) Kimberly Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rock Creek Ida — DATE OF BURIAL: Mar 28 1916

20. UNDERTAKER: none — ADDRESS:

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36
Primary Registration District No.
File No. 13762
Registered No. 23

1. PLACE OF DEATH
County of Twin Falls
City of Hansen
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennie Patterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. (Month) 7 (Day) 1907 (Year)

7. AGE: 8 Yrs. 3 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: M. A. Patterson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elizabeth Staines

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Elizabeth Patterson
(Address) Hansen Ida.

15. Filed Apr 5 1916 J N Davis Local Registrar

BYNS - YORK CO., PTRS. & SOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1916, to Apr 3 1916, that I last saw her alive on Apr 3 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia,
Terminal,
(Duration) Yrs. 4 mos. ds.
Contributory (Secondary) Chron. Endocarditis
(Duration 2 yrs. 2 mos. 15 ds.

(Signed) J N Davis M. D.
4/5 1916 (Address) Kimberly Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clifton Utah
DATE OF BURIAL: 191

20. UNDERTAKER: J. P. Grossman
ADDRESS: Twin Falls

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 19763
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Kimberly

Registration District No. 31
Primary Registration District No.
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cecil R. Ridgeway

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 17 (Day) 1913 (Year)

7. AGE: 3 yrs. 9 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kimberly, Idaho

10. NAME OF FATHER: Gail Ridgeway

11. BIRTHPLACE OF FATHER (State or Country): Clark, Mo.

12. MAIDEN NAME OF MOTHER: Goldie May Swearingen

13. BIRTHPLACE OF MOTHER (State or Country): Stockham Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs F. W. Swearingen
(Address) Kimberly Idaho

15.
Filed Mar 13 1916
J. S. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 3 1916, to Mar 12 1916
that I last saw him alive on Mar 11 1916
and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Gastro-Enteritis
(Duration) yrs. mos. 5 ds.
Contributory Bronchitis
(Secondary)
(Duration) yrs. mos. 6 ds.

(Signed) J. S. Davis M. D.
Mar 13 1916 (Address) Kimberly Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: 3/13 1916

20. UNDERTAKER: C. J. Crosby
ADDRESS: Twin Falls, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13764

Registered No. 22

1. PLACE OF DEATH.

County of Twin Falls

City of ..... (No. ....., ... St.)

Registration District No. 36

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FULL NAME Jas Henry Boyd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. 13 (Month) (Day) 1893 (Year)

7. AGE: 22 Yrs. 5 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Colo.

10. NAME OF FATHER: John A Boyd

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Leona Hudson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Leona Boyd Mountain Home Ida

15.

Filed Mar 25 1916

J. M. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 6 1916, to Mch 21 1916, that I last saw him alive on Mch 21 1916, and that death occured on the date stated above, at 3- P.M.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis

.....

.....

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) Lobar Pneumonia

(Duration ..... yrs. ..... mos. 6 ds.

(Signed) Dr A Dr Caitt M. D.

3-23 1916 (Address) Mountain Home Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Twin Falls — DATE OF BURIAL: 3-25 1916

20. UNDERTAKER: Thos J Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006.
(No. ..... St.)

File No. 13765
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Raymond G Cummins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Sep (Month) 6 (Day) 1891 (Year)
7. AGE: 24 Yrs. 24 Mos. 6 ds. 5h
IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher (school)
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: G. D Cummins
11. BIRTHPLACE OF FATHER (State or Country): Wis
12. MAIDEN NAME OF MOTHER: Elizabeth Coates
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G D Cummins
(Address) Nampa Ida
15. Filed Mar 13 1916 Ora D Calonge Local Registrar
Anna Garfield Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 11 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1916, to Mar 7 1916, that I last saw him alive on Mar 7 1916, and that death occured on the date stated above, at 7.30 P. M.
The CAUSE OF DEATH* was as follows:
Pulmonary Hemorrhage
5 minutes (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pulmonary Tuberculosis
(Duration 2 yrs. 6 mos. ..... ds.
(Signed) W P Ross M. D.
3/13 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lakeview Cem — DATE OF BURIAL: 3-13 1916
20. UNDERTAKER: Fred Robinson — ADDRESS: Nampa

SYMS - YORK CO., PTRS.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
(No. ..... St.)

File No. 13766
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marvin Lester Nash

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 11 (Day) 1911 (Year)

7. AGE: 4 Yrs. 9 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: 0
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A L Nash

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Maud Mills

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A L Nash
(Address) Nampa Ida

15. Filed May 14 1916 D. A. Clarke Local Registrar
Amelia Mayfield Deputy.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Mch~~ 10 1916, to Mch 14 1916, that I last saw him alive on March 14 1916, and that death occured on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:
Pulmonic abcess ruptured
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Pneumonia
(Duration ..... yrs. ..... mos. 12 ds.
(Signed) F. B. Smith M. D.
19 ..... (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerdown Cem — DATE OF BURIAL 191

20. UNDERTAKER: Fred E Robinson — ADDRESS Nampa

8V168 - YORK CO., PTG. & LITHO. CO.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13767

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of .....

Registration District No. 7

Primary Registration District No. 1006.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Surber

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sep (Month) 1 (Day) 1847 (Year)

7. AGE: 70 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Abrahom Surber

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Oscar O Ofold
(Address) Nampa Ida

15. Filed Mar 27 1916 Dr D Calonge Local Registrar
Agnes Rutherford Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20th 1916, to Mar 25th 1916, that I last saw him alive on Mar 25th 1916, and that death occured on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorhage

..... (Duration) ..... Yrs. ..... mos. 2 hrs. ..... ds.

Contributory (Secondary) Arterio sclerosis

..... (Duration 10 yrs. ..... mos. ..... ds.

(Signed) H. T. Ross M. D.

3/27 1916 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parkerlawn Cem — DATE OF BURIAL: 3-27 1916

20. UNDERTAKER: Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO. [illegible]

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH 7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13768

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Nampa

(No. ....., ... St.)

Registration District No. .....

Primary Registration District No. 2006

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Forwin Dodds

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. June (Month) 30 (Day) 1850 (Year)

7. AGE: 65 Yrs. 8 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)... Dairying

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER Jesse Dodds

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Margaret Shannon

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. M. Dodds

(Address) Parma, Idaho

15. Filed May 17 1916 W. D. Calonge Local Registrar

Anna Hatfield Deputy.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 6 1916, to Mar. 15 1916, that I last saw him alive on Mar. 10 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. G. Hausman M.D. ~~M. D.~~

3/17 1916. (Address) Nampa, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn — DATE OF BURIAL: Mar 17 1916

20. UNDERTAKER: F. K. Robinson — ADDRESS: Nampa Ida

SYMS - YORK CO., PTG.

FORM V. S. No. 5-25 rev. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 21

Primary Registration District No. 2022

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13769

Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Blaine

City of Hailey.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fredrick Joseph Wondershek.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. (Month) 10. (Day) 1915. (Year)

7. AGE: ..... Yrs. 9 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Hailey, Ida.

10. NAME OF FATHER: F. A. Wondershek.

11. BIRTHPLACE OF FATHER (State or Country): Belleve, Ida.

12. MAIDEN NAME OF MOTHER: Louise Lehn.

13. BIRTHPLACE OF MOTHER (State or Country): Washington.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. F. A. Wondershek.

(Address) Hailey.

15. Filed Mar 7 1916. Robert H. Wright, Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 5th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3 1916, to March 5 1916, that I last saw him alive on March 5 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows: Intestinal Intussusception

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) John D. Cook M. D.

1916 (Address) Hailey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hailey Ida	Mar 10 1916
20. UNDERTAKER	**ADDRESS**
R. D. Harris	Hailey Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 21

Primary Registration District No. 2045

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13770

Registered No. 7

1. PLACE OF DEATH.
County of Blaine
City of Carey
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Perry G. Parke.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. April (Month) 30 (Day) 1878 (Year)

7. AGE: 37 Yrs. 11 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Albion, Ida.

10. NAME OF FATHER: Thompson Parke.

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Julia Sessions.

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Park O'Kelley
(Address) Hailey, Ida.

15. Filed Mar 18 1916

R. Robertshaw
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1913, to Mar 17 1916, that I last saw him alive on Feb 24 1916, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Tuberculosis

(Duration) 9 Yrs. — mos. — ds.

Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.

(Signed) R. Robertshaw M. D.
Mar 17 1916 (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Carey Ida — DATE OF BURIAL: 3/19 1916

20. UNDERTAKER: W. H. Harris — ADDRESS: Hailey Ida.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13771
Registered No. 8

1. PLACE OF DEATH.
County of Blaine
City of Bellevue
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2022
(No. ..., ... St.)

2. FULL NAME Sylvester Roland Shepherd

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 25 (Day) 1840 (Year)

7. AGE: 75 yrs. 7 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Jacob Shepherd

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Lucy Lanam

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O J Allen, MD
(Address) Bellevue Idaho

15. Filed Mch 24 1916 Robert L Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1915, to Mch 1916 that I last saw him alive on Mch 22 1916, and that death occurred on the date stated above, at 11 9 M.

The CAUSE OF DEATH* was as follows:
Senility
Confined to bed
(Duration) ... yrs. 1 mos ... ds.
Contributory (Secondary) None
(Duration) ... yrs. ... mos. ... ds.

(Signed) O. J. Allen M. D.
19 ... (Address) Bellevue Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellevue Ida
DATE OF BURIAL: Mch 24 1916

20. UNDERTAKER: R. D. Harris
ADDRESS: Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13772
Registered No. 27

1. PLACE OF DEATH.
County of Latah
City of Kendrick

Registration District No. 63
Primary Registration District No. 7143
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vena Irene Rogers

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: Dec. (Month) 20 (Day) 1914 (Year)

7. AGE: 1 yrs. 2 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kendrick Idaho.

10. NAME OF FATHER: James C Rogers

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Meta C Heck

13. BIRTHPLACE OF MOTHER (State or Country): Penn'y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer E. Bechtol
(Address) Kendrick Ida.

15. Filed Mch 12 1916 — J E Hoyt, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 11th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1916, to March 11 1916, that I last saw h[illegible] alive on March 10 1916 and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
Broncho-pneumonia -

..... (Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) Auto-intoxication -
..... (Duration) ..... yrs. 8 mos. ..... ds.

(Signed) Arthur W Patton M.D.
Mch 12 1916 (Address) Kendrick, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kendrick Cemetary Kendrick Idaho
DATE OF BURIAL: Mch 12 1916

20. UNDERTAKER: Elmer E. Bechtol
ADDRESS: Kendrick Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13773
Registered No. 26

1. PLACE OF DEATH.
County of Latah
City of Kendrick
Registration District No. 63
Primary Registration District No. 2143
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bothilda Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept. (Month) 30th (Day) 1863 (Year)

7. AGE: 62 yrs. 6 mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Nels Nelson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tonia Nelson
(Address) Kendrick Idaho

15. Filed Apr. 7 1916 — J E Hoyt — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st 1915, to Mar. 30th 1916 that I last saw her alive on Mar 30th 1916 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Cancer

..... (Duration) 2 yrs. 6 mos. ..... ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Rothwell M. D.
Apr. 6. 1916 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kendrick Idaho
DATE OF BURIAL: Apr. [illegible] 1916

20. UNDERTAKER: Elmer Bechtol
ADDRESS: Kendrick Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Kendrick
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No. 2143
(No. ....., ... St.)

File No. 13774
Registered No. 25
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Mathias Cain

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH: Sep (Month) 14 (Day) 1874 (Year)

7. AGE: 41 yrs. 6 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Isle of Mann England

10. NAME OF FATHER: John Cain

11. BIRTHPLACE OF FATHER (State or Country): Isle of Mann

12. MAIDEN NAME OF MOTHER: Belle Curphey

13. BIRTHPLACE OF MOTHER (State or Country): Isle of Mann

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Wm. Cain
(Address) Kendreen Idaho

15.
Filed March 23 1916 J. E. Hoyt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 1 1915, to March 22 1916, that I last saw him alive on March 21 1916, and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:
Pernicious Anemia

(Duration) One yrs. — mos. — ds.

Contributory (Secondary) none
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Hoyt M. D.
3-23-1916 (Address) Kendrick, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
American Ridge Cemetery	3 24 1916
20. UNDERTAKER: E. E. Bechtol	ADDRESS: Kendrick Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13775

Registered No. 3

1. PLACE OF DEATH.

County of Lincoln

City of Richfield

(No. ....., ... St.)

Registration District No. 17

Primary Registration District No. 1160

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James M Richardson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb. (Month) 16 (Day) 1849 (Year)

7. AGE: 64 Yrs. ..... Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: James Richardson

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: don't Known

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Richardson

(Address) Richfield

15. Filed 3/25th 1916

J Leitch
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Did not attend deceased. Permission obtained from Son. Subject cause of death, was due to organic heart trouble

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Produced by infirmity Rheumatism

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) P. J. Scanlon M. D.

3/27 1916 (Address) Richfield Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: ~~Richfield~~

DATE OF BURIAL: 3/26 1916

20. UNDERTAKER ~~Undertaking~~: James Leitch

ADDRESS: ~~Richfield~~ Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 126

County of Kootenai

Primary Registration District No. 2204

City of Harrison Idaho (No. ....., ... St.)

File No. 13776

Registered No. 72

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patrick Maloney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): single

6. DATE OF BIRTH: not known

(Month) (Day) (Year)

7. AGE: 87 yrs. — mos. — ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jas Jones

(Address) Harrison Idaho

15.

Filed April 7 1916 R. S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: march 26 1916

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1915, to mch 26 1916, that I last saw him alive on march 25 1916, and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Ruptured compensation

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H W Dedier M. D.

Mch 27 1916 (Address) Harrison, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Harrison Cem — DATE OF BURIAL: 9/2 1916

20. UNDERTAKER: Ervin Luds — ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13777

Registered No. 11

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No. 12

Primary Registration District No. 2204

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 1 (Month) ..... (Day) 1 (Year)

7. AGE: 91 Yrs. 6 Mos. ✓ ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None of age

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Toronto Canada

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. J. Whalen

(Address) Coeur d'Alene Idaho

15. Filed April 7 1916 — R. S. Jensen, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 29 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191.., to ✓ 191.., that I last saw h... alive on ..... 191.., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Was Called the day after death for purpose of making death Certificate

(Duration) ✓ Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ✓ yrs. ✓ mos. ✓ ds.

(Signed) C. E. Wm[illegible] M. D.

3/30 1916 (Address) Rural Valley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) P. J. Whalen

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? ..... My years

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Missim Cemetery — DATE OF BURIAL: 3/30 1916

20. UNDERTAKER: Hays & Yaeger — ADDRESS: Spokane

SYMS - YORK CO., PTRS. & PRINT. $4000

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Star, Ida
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1001
Primary Registration District No. 1
(No. ..... St.)

File No. 13779
Registered No. 79
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Floyd Baldwin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W	

6. DATE OF BIRTH: Mch (Month) 12 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Star Idaho

10. NAME OF FATHER: Clarke M. Baldwin

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Edda Drake

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lydia Baldwin
(Address) Star Idaho

15. Filed 3-31 1916 Chester Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 28 1916, to Mch 31 1916, that I last saw he alive on Mch 31 1916, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
Mch 31 1916. (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetary | DATE OF BURIAL: Apr 1 1916

20. UNDERTAKER: Fry Funeral Home | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 9

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7001

Primary Registration District No. 7001

File No. 13780

Registered No. 52

1. PLACE OF DEATH.

County of Ada

City of [illegible]

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edmund Morcom

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	White.	Mar[illegible]

6. DATE OF BIRTH.

May (Month) 18 (Day) 1838 (Year)

7. AGE

77 Yrs. 8 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) England.

10. NAME OF FATHER Edmund Morcom.

11. BIRTHPLACE OF FATHER

(State or Country) England.

12. MAIDEN NAME OF MOTHER Not Obtainable.

13. BIRTHPLACE OF MOTHER

(State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J R Morcom

(Address) .....

15. Filed 7-9 1916 Ed Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Old Malarial Cattle off Track

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Extreme Dropsy

.....(Duration 2 plus yrs. ..... mos. ..... ds.

(Signed) Ed Hall M. D.

19.... (Address) Star, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Feb 11 1916

20. UNDERTAKER: Fry & Summers Co. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Star Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1001
Primary Registration District No.
(No. , St.)

File No. 13781
Registered No. 78
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mabel Morcom

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 2 (Day) 1899 (Year)

7. AGE: 16 yrs. 7 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Delmar, Idaho

10. NAME OF FATHER: James Hebert Morcom

11. BIRTHPLACE OF FATHER (State or Country): California

12. MAIDEN NAME OF MOTHER: Cristie McAskell

13. BIRTHPLACE OF MOTHER (State or Country): Nevada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J R Morcom
(Address) Star, Idaho

15. Filed April 6 1916 Courtney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191..., that I last saw h— alive on ——— 191..., and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows: Unknown - Mobil by Runaway Kraft. Died before my arrival - Coner
(Duration) yrs. 4 hrs ds.
Contributory (Secondary) Unknown.
(Duration) yrs. mos. ds.
(Signed) C E Hall M. D
19... (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetary
DATE OF BURIAL: ...191...

20. UNDERTAKER
ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 7001
File No. 13782
Registered No. 31

1. PLACE OF DEATH.
County of Canyon
City of Meat Star (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William P. Kennedy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan 28 (Month) (Day) 1863 (Year)

7. AGE: 53 yrs. 0 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Donald W Kennedy

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Anna McDougall

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. W. Kennedy
(Address) Ola Idaho

15. Filed 7-1 1916 Overton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 1916, to July 31 1916, that I last saw h~~er~~ alive on July 31 1916, and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(Duration) 8 hours ds.

Contributory (Secondary) Unknown
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
19 (Address) [illegible] Star Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery | DATE OF BURIAL: Aug 3 1916

20. UNDERTAKER: Frye & Summers | ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 91

File No. 13786

County of Bonneau

Primary Registration District No.

City of Dessmet Ida

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Magnus A Rosenberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unknown (Month) — (Day) 1854 (Year)

7. AGE: 62 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: FARMER

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Berglund

(Address) Tensed Idaho

15.

Filed March 3rd 1916 John Foot Asst. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st 1916, to March 1st 1916, that I last saw h.im alive on Feb 26th 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute Intoxication of Heart

Acute Myocarditis

(Duration) Unknown Yrs. — mos. — ds.

Contributory (Secondary) Chronic Endocarditis

(Duration) Unknown — mos. — ds.

(Signed) Eugene M. Hale M. D.

March 1916 (Address) Desmet Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Tekoa Wash

DATE OF BURIAL: Mch 3, 1916

20. UNDERTAKER: C L. Sellwood

ADDRESS: Tekoa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & BOOK. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
(No. .... St.)

File No. 13787
Registered No. .....

1. PLACE OF DEATH.
County of Latah.
City of Potlatch

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myrtle Alice Smith.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH. March. (Month) 22. (Day) 1916 (Year)

7. AGE: .....Yrs. .....Mos. 1 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Aaron V. Smith.

11. BIRTHPLACE OF FATHER (State or Country): Waldessia. Kansas.

12. MAIDEN NAME OF MOTHER: Gertie Bennett.

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Aaron V. Smith.
(Address) Potlatch Idaho.

15. Filed March. 23 1916. D. J.W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March. (Month) 23. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 22 1916, to March. 23. 1916, that I last saw h[illegible] alive on March. 22 1916, and that death occured on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Asthenia following.
Premature birth.
.....(Duration) .....Yrs. .....mos. 1 ds.

Contributory (Secondary) .....
.....(Duration .....yrs. .....mos. .....ds.

(Signed) J.W. Thompson M. D.
3/23/1916 (Address) Potlatch Idaho

*State the [illegible]SE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF I[illegible] and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENG[illegible] OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery. DATE OF BURIAL: March. 23 1916

20. UNDERTAKER: Parents. ADDRESS: Potlatch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNE - YORK CO., PTRS. & BORS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2007

File No. 13788

County of Canyon

City of ..... (No. ....., ... St.)

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl Wilford Osborne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	S

6. DATE OF BIRTH: Feb (Month) 10 (Day) 1916 (Year)

7. AGE: ..... yrs. 1 mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canyon Co

10. NAME OF FATHER W J Osborne

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Mary Simpson

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Osborne
(Address) .....

15. Filed March 27 1916 Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 5 1916, to Mch 23 1916, that I last saw him alive on Mch 23 1916, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Indigestion with convulsions

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. B. Allen M. D.
3-23 1916 (Address) Parma Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilder — DATE OF BURIAL: Mch 24 1916

20. UNDERTAKER: Osborn Bros Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9

Primary Registration District No. 2007

File No. 13789

County of Canyon

City of ..... (No. ....., ... St.)

Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elsie Stradley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Sept (Month) 9 (Day) 1837 (Year)

7. AGE: 79 yrs. 6 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): None

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Lorenza Dow Wiseman

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Celia Olmans

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margaret A Bradney
(Address) Parma Ida

15. Filed 8-5-1916 Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2d 1916, to April 4 1916, that I last saw her alive on April 3rd 1916, and that death occurred on the date stated above, at 7-25 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary): senile debility

(Duration) — yrs. — mos. — ds.

(Signed) William R. Mallory M. D.

Apr. 5 1916 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Roswell — DATE OF BURIAL: April 5 1916

20. UNDERTAKER: Beckham Bros Co — ADDRESS: Parma

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. [redacted] E OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13790
Registered No. 5

1. PLACE [redacted] trict No. 50
County of Lew[redacted] ration District No. 2129
City of Ke[redacted] St.)

If death occurs away from usual residence, give facts called for under special information.

2. FU[redacted]ME James A. Armstrong. (James)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 5 (Day) 1864 (Year)

7. AGE: 51 yrs. 11 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teamster.
(b) General nature of industry business, or establishment in which employed (or employer): Owned & worked four horses.

9. BIRTHPLACE (State or Country): Washington Wash.

10. NAME OF FATHER: Abner Armstrong

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Armstrong
(Address): Volfmer Ida

15. Filed Mch 29 1916 R E Dunlap Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Have not attended him 191 , to 191 ; that I last saw h alive on Mar 10 1916, and that death occurred on the date stated above, at [redacted] M.

The CAUSE OF DEATH* was as follows:
Probably apoplexy, died suddenly after a hearty supper following a days work in field.
(Duration) yrs. mos. ds.
Contributory (Secondary) History of paralytic stroke few years ago.
(Duration) yrs. mos. ds.

(Signed) E. L Bunts M. D.
19 (Address) Volfmer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
IOOF Cemetery	March 29 1916
20. UNDERTAKER	ADDRESS
Stockton & Dwyer Co.	Ke[redacted] Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

I enclose
from Dr Rourke that he
communicated with the
Coroner who sanctioned
the certificate as it is
P & Dunlop.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 40
Primary Registration District No.
(No. ..... , ... St.)

File No. 13791
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Hollister

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hope Darlington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Sept. (Month) 20 (Day) 1908 (Year)

7. AGE
7 Yrs. 4 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Boise - Idaho

10. NAME OF FATHER E. B. Darlington

11. BIRTHPLACE OF FATHER
(State or Country) Penna.

12. MAIDEN NAME OF MOTHER Mabel R. Kratz

13. BIRTHPLACE OF MOTHER
(State or Country) Penna

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. M. Hall
(Address) Hollister Ida

15.
Filed Feb. 13 1916 W. A. Parrett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 11 1916, to Feb. 13 1916, that I last saw her alive on Feb. 13 1916, and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Intestinal Obstruction

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) None
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Parrett M. D.
19..... (Address) Hollister, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Feb. 18 1916

20. UNDERTAKER: C. J. Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13792

Registered No. .....

Registration District No. 40

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of Rogerson

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Austin Wm Leraig.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 20 (Day) 1912 (Year)

7. AGE: 4 Yrs. ..... Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Lincoln Co. Nebr.

10. NAME OF FATHER Jas. B. Leraig

11. BIRTHPLACE OF FATHER (State or Country) Jasper Co Mo.

12. MAIDEN NAME OF MOTHER Eleanor Austin

13. BIRTHPLACE OF MOTHER (State or Country) Illinoise

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jas. B. Leraig

(Address) Rogerson Idda.

15. Filed Mch 6 1916 W. A. Lane Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 29 1916, to Mar 3 1916, that I last saw him alive on Mar 2 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Acute infectious nephritis

.....(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Acute tonsilitis

.....(Duration ..... yrs. ..... mos. 7 ds.

(Signed) P. D. Goldsmith M. D.

Mar 4 1916 (Address) Rogerson Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rogerson — DATE OF BURIAL: Mch 4 1916

20. UNDERTAKER: C. J. Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cuyhee
City of Bruneau
(No. —, — St.)

Registration District No. 44
Primary Registration District No. 212

File No. 16
Registered No. 13793

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bryan Stone

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH: Sept 20 (Month) (Day) 1896 (Year)

7. AGE: 19 yrs. 6 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Riddle Idaho

10. NAME OF FATHER: R D Stone

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Annie Partlock

13. BIRTHPLACE OF MOTHER (State or Country): United States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed 4/5 1916 J C Bartlett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916, to Apr 4 1916, that I last saw him alive on Apr 4 — 1916, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 11 mos. — ds.

Contributory (Secondary) Hemorrhage from lungs

(Duration) yrs. mos. ds.

(Signed) J. C. Bartlett M.D.
4/6 1916 (Address) Bruneau Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riddle Idaho
DATE OF BURIAL: Apr. 5 1916

20. UNDERTAKER: None
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 13794
Registered No. 10

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lester Bacus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH
October (Month) 25. (Day) 1915 (Year)

7. AGE
~~1~~ yrs. 4 mos. 15 ds.
IF LESS than 1 day how many .....*hrs. or* .....*mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho Co.

10. NAME OF FATHER Harvey Bacus

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Ruth. Krier

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harvey Bacus.
(Address) Grangeville

15.
Filed April 1 1916 G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3 1916, to March 11 1916, that I last saw him alive on March 11 1916, and that death occurred on the date stated above, at 11 p.M.

The CAUSE OF DEATH* was as follows:
Cerebro-spinal fever

(Duration) ..... yrs. ..... mos. 9 ds.
Contributory
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jesse L Rains M. D.
Mch. 12 1916 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Mch 12 1916

20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 718/

File No. 13795

County of Idaho

City of Mt Idaho (No. ....., ... St.)

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph E Callan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH: March (Month) 19 (Day) 1858 (Year)

7. AGE: 57 yrs. 11 mos. 15 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE: Wisconsin (State or Country)

10. NAME OF FATHER: Michle Callan

11. BIRTHPLACE OF FATHER: Irland (State or Country)

12. MAIDEN NAME OF MOTHER: Mcentee

13. BIRTHPLACE OF MOTHER: Penn (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Calla n
(Address) Grangeville Idaho

15. Filed April 1 1916 GS Stricklin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 4 1916 to Mch 4 1916 that I last saw him alive on ..... 191- and that death occurred on the date stated above, at unknown M.

The CAUSE OF DEATH* was as follows:

Found dead in bed -

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stricklin M. D.

3/4 1916 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View | DATE OF BURIAL: 3-6 1916

20. UNDERTAKER: W E Graham | ADDRESS: Grangeville

GYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho

City of Grangeville

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103

Primary Registration District No. 1001

(No. ..... St.)

File No. 13797

Registered No. 12

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 2 (Day) 1843 (Year)

7. AGE: 73 yrs. 3 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: William White

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Martha Sexton

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J B White
(Address) Nezperce, Idaho

15. Filed April 1 1916 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1916, to March 27 1916, that I last saw him alive on March 27 1916, and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Pyuria and cardiac asthenia

(Duration) — yrs. 3 mos. — ds.

Contributory (Secondary) Arteriosclerosis

(Duration) uncertain yrs. mos. 1 ds.

(Signed) O. M. Slocum M. D.

March 1916 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: 3/29 1916

20. UNDERTAKER: E Hancock — ADDRESS: Grangeville

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181
(No. ..... St.)

File No. 13798
Registered No. 11
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joel Sturgis Shearer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH: Jan 29 (Month) (Day) 1851 (Year)

7. AGE: 65 yrs. 1 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shantaugh, Iowa

10. NAME OF FATHER: Joel Shearer

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Emily

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter L. Bash
(Address) Grangeville

15. Filed April 1 1916 G S Stricklin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 13 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1915, to Mch 13 1916, that I last saw h— alive on Jan 5 1916 and that death occurred on the date stated above, at 6:45 PM

The CAUSE OF DEATH* was as follows:

Orchal Hemorrhage

(Duration) ..... yrs. 2 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G D Stricklin M. D.

3/13 1916 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Harpster Ida	Mch 15 1916

20. UNDERTAKER	ADDRESS
W E Graham	Grangeville

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13800

Registered No. .....

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ada
City of Meridian

Registration District No. 62
Primary Registration District No. 24
(No. ....., ... St.)

If death occurs away from usual residence, *give facts* called for under special information.

2. FULL NAME Nettie M. Downing

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): married

6. DATE OF BIRTH: March 16 1847
(Month) (Day) (Year)

7. AGE: 69 yrs. ..... mos. 4 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Ellef Johnson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Martelee

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jacob Downing
(Address) Meridian Idaho

15.
Filed March 20 1916 W. H. Eheen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 20 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1915, to March 14 1916
that I last saw her alive on March 14 1916
and that death occurred on the date stated above, at 8A M.

The CAUSE OF DEATH* was as follows:

Uremia

..... (Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) Nephritis

..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) W. H. Eheen M. D.

3-21 1916 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian
DATE OF BURIAL: March 21 1916

20. UNDERTAKER: F E Lambert
ADDRESS: Meridian Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Genesee (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 62
Primary Registration District No. 2142

File No. 13801
Registered No. 3
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jacob S. Rogers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: January 12 1845
(Month) (Day) (Year)

7. AGE: 71 yrs. 2 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Rogers

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Ramsey

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. T. Rogers
(Address) Genesee Idaho

15. Filed Mch. 20th 1916 W. K. Eheen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 17 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1916, to March 17 1916
that I last saw h— alive on March 17 1916,
and that death occurred on the date stated above, at 1P M.

The CAUSE OF DEATH* was as follows:

Nephritis
(Duration) ..... yrs. ..... mos. 2 ds.
Contributory Cancer of Face
(Secondary)
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) W. K. Eheen M. D.
3/19 1916 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt. View Cem
DATE OF BURIAL: 3-20 1916

20. UNDERTAKER: F. E. Lambert
ADDRESS: Genesee Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62
Primary Registration District No. 2142
File No. 13802
Registered No. 4

1. PLACE OF DEATH.
County of Latah
City of Genesee (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Dallas G. Roseman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March 9 1916 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: /
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Genesee

10. NAME OF FATHER: G D Roseman

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Anna Moorlock

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. D. Roseman
(Address) .....

15. Filed 3-14 1916 W. F. Ehrman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 13 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9 1916, to 3-13 1916
that I last saw him alive on 3-13 1916
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia.

..... (Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Suppression of Urine
..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) W. F. Ehrman M. D.
3-14 1916 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Luth. Cem. DATE OF BURIAL: 3-15 1916

20. UNDERTAKER: Rodde ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13804
Registered No. .....

Registration District No. 4
Primary Registration District No. .....

1. PLACE OF DEATH.
County of Gem
City of Emmett
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Boyd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR, DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 80 yrs ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Do not know

11. BIRTHPLACE OF FATHER (State or Country): " " "

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W B Reese
(Address) Emmett Idaho

15.
Filed Mar 15 1916 — J. L. Reynolds, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Heart no physician
died during night while
alone. had not been sick
probably (Duration) heart Yrs. disease Mos. ..... ds.
Contributory (Secondary) no Post Mortem
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. L. Reynolds M. D.
3/16 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 3/16 1916

20. UNDERTAKER: O. O. Dickenson — ADDRESS: Emmett

BYRNE - YORK CO., PTRS. & BKBS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Cambridge
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 88
Primary Registration District No. 2164
(No. ....., ... St.)

File No. 13805
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Denny Lobe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mar 11 (Month) 1916 (Day) (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 20 mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Babe
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Cambridge Idaho

10. NAME OF FATHER: James Denny.

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ethel Shaw

13. BIRTHPLACE OF MOTHER (State or Country): Midvale Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O E Schmuck
(Address) Cambridge Ida.

15. Filed April 1 1916 O E Schmuck Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 11 1916, to Mar 11 1916, that I last saw him alive on Mar 11 1916, and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O E Schmuck M. D.
April 1 1916 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho — DATE OF BURIAL: Mar 13 1916

20. UNDERTAKER: Jas Anderson — ADDRESS: Cambridge Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 88
Primary Registration District No. 2164
File No. 13806
Registered No.

1. PLACE OF DEATH.
County of Washington
City of Cambridge
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Effie Denning

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	W	married

6. DATE OF BIRTH
May 1 (Month) May (Day) 1886 (Year)

7. AGE
29 yrs. 9 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Nebraska Idaho

10. NAME OF FATHER Wellmin Shaw

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Mary Dunn

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas Denning
(Address) Cambridge Idaho

15.
Filed April 1 1916 O E Schmutz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 11 1916, to Mar 11 1916, that I last saw her alive on Mar 11 1916, and that death occurred on the date stated above, at 10 PM.

The CAUSE OF DEATH* was as follows:
Hemorrhage. Rupture of Uterus

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Child birth

(Duration) ..... yrs. ..... mos. 1 ds.
(Signed) O E Schmutz M. D.
April 1 1916 (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho — DATE OF BURIAL: Mar 13 1916

20. UNDERTAKER: Jas Hutchison — ADDRESS: Cambridge Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 88
Primary Registration District No. 2164
File No. 13807
Registered No. .....

1. PLACE OF DEATH.
County of Washington
City of Cambridge
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orren Hawley Keeler

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 19 (Day) 1902 (Year)

7. AGE: 13 Yrs. 10 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Fredrick Keeler

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Emma Thomson

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fredrick Keeler
(Address) Cambridge Ida

15. Filed April 1 1916 O E Schumm Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 22 1916, to Mar 22 1916, that I last saw h. alive on Mar 22 1916, and that death occured on the date stated above, at 11 15 P.M.

The CAUSE OF DEATH* was as follows:
Appendicitis February 5
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Peritonitis
(Duration) ..... yrs. ..... mos. 1 ds.
(Signed) Simeon Hodder M. D.
19..... (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida — DATE OF BURIAL: Mar 24 1916

20. UNDERTAKER: Jos Hendelsman — ADDRESS: Cambridge Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13808

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of Filer

Registration District No. 38

Primary Registration District No. 2086

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harriet Ellen Brown

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Oct (Month) 7 (Day) 1850 (Year)

7. AGE: 65 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Bates Illinois

10. NAME OF FATHER: Wm. Dryden

11. BIRTHPLACE OF FATHER (State or Country): Jefferson Co. Ind

12. MAIDEN NAME OF MOTHER: Eliza A. Logan

13. BIRTHPLACE OF MOTHER (State or Country): Jefferson Co Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F D Brown

(Address) Filer

15. Filed 3-18 1916 A A Newberry Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 3 1916, to Mar 18 1916, that I last saw h[er] alive on Mar 18 1916, and that death occured on the date stated above, at 11:50 P.M.

The CAUSE OF DEATH* was as follows:

Probably Carcinoma of Liver

..... (Duration) ✓ Yrs. ✓ mos. ✓ ds.

Contributory (Secondary) Valvular Heart Disease

..... (Duration ✓ yrs. ✓ mos. ✓ ds.

(Signed) A A Newberry M. D.

3-18 1916 (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Cem — DATE OF BURIAL: Mar 21 1916

20. UNDERTAKER: J E Drake — ADDRESS: Filer

County of Bingham

City of Shelley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. [illegible]

Primary Registration District No. 747

(No. ..... St.)

2. FULL NAME George Oler

BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
File No. 13809
Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced. (Write the Word): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) ..... 191... (Year)

7. AGE. 67 Yrs. 5 Mos. 27 ds.
IF LESS than 1 day, how many.....hrs. or .....min.?

8. OCCUPATION.
(a) Trade, profession or partcular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE. (State or Country) Pa

10. NAME OF FATHER: George Oler

11. BIRTHPLACE OF FATHER (State or Country): US

12. MAIDEN NAME OF MOTHER: Margaret Lancaster

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Oler
(Address) Shelley Idaho

15. Filed 1/23 191 6 Edwin Cutler Local Registrar.

Place Where Remains are to be Sent: American Falls Ida
Date of Shipment: 1/23 191 6

SHIPPING UNDERTAKER
ADDRESS Idaho Falls Ida Firm Name C E Dunwoody

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby 21 (Month) (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1915, to Feby 21 191 6; that I last saw him alive on 2/20 191 6, and that death occurred on the date stated above, at 7a M.

The CAUSE OF DEATH was as follows:
Acute dilatation of Heart

..... (Duration) ..... Years ..... mos. 14 ds.
Contributory (Secondary) Arteriosclerosis
..... (Duration) 3 Years ..... mos. ..... ds.
(Signed) Edwin Cutler M. D.
..... 191..... (Address) Shelley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Sucidial or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)
At place of death.....yrs.....mos.....days
In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL American Falls Ida
Date of Burial ..... 191...

20. UNDERTAKER C E Dunwoody
Address Idaho Falls Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 52a

Primary Registration District No. 2136

File No. 13810

County of Bear Lake

City of Montpelier (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myrtle Dean Bowcutt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH

Jan. (Month) 14 (Day) 1916 (Year)

7. AGE

..... yrs. 4 mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Albert Bowcutt

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Beatrice Irving

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Bowcutt

(Address) Montpelier Ida.

15.

Filed 4/1 1916 W. W. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1916, to Feb 1916, that I last saw him alive on Feb 1 1916, and that death occurred on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. A. Quayle M. D.

19 ..... (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Montpelier	2/3/1916
20. UNDERTAKER F. Sarbach	ADDRESS Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 52

County of Bear Lake Primary Registration District No. 2136

File No. 13811

City of Montpelier (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Raymond Blank

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Jan (Month) 11 (Day) 1884 (Year)

7. AGE: 32 yrs. 2 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired R. R.
(b) General nature of industry business, or establishment in which employed (or employer): employee

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: Wm Jno. Blank

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: Emma Jane Klein Lindsay

13. BIRTHPLACE OF MOTHER (State or Country): Ind Lindsay

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Lyon M.D.
(Address) Montpelier Ida

15. Filed March 15th 1916 H. H. King M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 13th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1915, to Mar 13th 1916 that I last saw him alive on Mar 8th 1916 and that death occurred on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Leakage of the heart

(Duration) 3 yrs. 0 mos. 0 ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Lyon M. D.

Mar 15 1916 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho | DATE OF BURIAL: 3/16 1916

20. UNDERTAKER: Vincent Bros. | ADDRESS: Montpelier

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 52
County of Bear Lake Primary Registration District No. 2136
City of Montpelier (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 13812
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Stephen Skinner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	married

6. DATE OF BIRTH: Sept 7 (Month / Day) 1877 (Year)

7. AGE: 38 yrs. 6 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bear Lake County Ida.

10. NAME OF FATHER: John Skinner.

11. BIRTHPLACE OF FATHER (State or Country): United States

12. MAIDEN NAME OF MOTHER: Jane Smith

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Lynn M. D.
(Address) Montpelier Ida.

15. Filed 3/29/1916 H. H. King Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 28th 1916 (Month / Day / Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21 1916, to March 29 1916, that I last saw him alive on March 29 1916, and that death occurred on the date stated above, at 12, M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary): None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Lynn M. D.

3/29 1916 (Address) Montpelier Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 7 days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence: Nonnan Idaho

19. PLACE OF BURIAL OR REMOVAL: Nonnan Idaho — DATE OF BURIAL: 3/30 1916

20. UNDERTAKER: John Skinner Jr. — ADDRESS: Nonnan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 13813
Registered No. 26

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Susie Poe Yager

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April (Month) 15 (Day) 1875 (Year)

7. AGE: 40 yrs. 11 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Ira Poe

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Sophina A. Chastine

13. BIRTHPLACE OF MOTHER (State or Country): Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. H. Yager
(Address) Moscow, Ida.

15. Filed Mch 18 1916 L F Roe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 16th 1916, to Mch 16 1916, that I last saw h[illegible] alive on Mch 16 1916, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Placenta Praevia

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Cedar M. D.
Mch 16 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ellensburg Wash — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Hen Grice — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. 515, North Main St.)

File No. 13814
Registered No. 25
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Driscoll

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH
May (Month) 1st (Day) 1822 (Year)

7. AGE
93 yrs. 10 mos. 19 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Florence Driscoll

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Ellen Holland

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Kathryn Driscoll
(Address) Moscow Idaho

15. Filed Mch 20 1916 J. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mch (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....191.., to Mch 19th 1916, that I last saw him alive on Mch 19th 1916, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy

(Duration) yrs. mos. 1 ds.
Contributory (Secondary) Old Age
(Duration) yrs. mos. ds.

(Signed) J. N. Clarke M. D.
19 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	3/21 1916
20. UNDERTAKER	ADDRESS
Allen & Price	Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 13815
Registered No. 23

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eliza Jane Franklin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH
Mch (Month) 2 (Day) 1838 (Year)

7. AGE
78 yrs. ..... mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) North Carolina

10. NAME OF FATHER John Kirk

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John K. Franklin
(Address) .....

15. Filed Mch 25 1916 S T Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mch (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16* 1916, to Mch 24 1916, that I last saw her alive on Mch 16 1916, and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:
Diabetes

(Duration) 2 yrs. ..... mos. ..... ds.
Contributory (Secondary) Senility
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Adair M. D.
Mch 25 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Moscow
DATE OF BURIAL 3/26 1916

20. UNDERTAKER Glen O Price
ADDRESS Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 13816
Registered No. 24

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. 315 East 5th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Jasper Branson
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Jan (Month) 31 (Day) 1856 (Year)

7. AGE
60 yrs. 1 mos. 21 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Tennessee

10. NAME OF FATHER John Branson

11. BIRTHPLACE OF FATHER (State or Country) Tennessee

12. MAIDEN NAME OF MOTHER Rebecca Jane Lacy

13. BIRTHPLACE OF MOTHER (State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Elbert Branson
(Address) Moscow Idaho

15. Filed Mch 22 1916 D F Rice Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13th 1916, to March 21 1916, that I last saw him alive on " " 1916, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis

Perhaps (Duration) 3 yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) F. M. Leitch M. D.
3/22 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 3/23 1916

20. UNDERTAKER: Glen O Guild — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of T Falls
City of " "

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 13819
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Willard Oliver Russell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant.

6. DATE OF BIRTH. Feb. (Month) 13 (Day) 1916 (Year)

7. AGE: .....Yrs. 6 Mos. 30 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Twin Falls Co. Ida.

10. NAME OF FATHER: Charles Russell.

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: M. Blanche Pringle

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas Russell
(Address) Twin Falls

15. Filed 2 [illegible] 1916 J. H. Coughlin Local Registrar

SYMS - YORK CO. PTHS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febry (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-9 1916, to 2-13 1916, that I last saw h~~im~~ alive on 6 P M 1916, and that death occured on the date stated above, at 10:30 P M.

The CAUSE OF DEATH* was as follows:
Cervical Abscess

(Duration) ..... Yrs. ..... mos. 2 1 ds.

Contributory (Secondary) LaGrippe

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Morgan M. D.

19.... (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Feb 15 1916

20. UNDERTAKER: Goodman & Evans — ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 108 37
Primary Registration District No. 2085

File No. 13820
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josephine Bailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 15 (Day) 1915 (Year)

7. AGE: 1 Yrs. X Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Lehi, Utah

10. NAME OF FATHER: M B Bailey

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Della V. Woodhouse

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M B Bailey
(Address) Montaugh

15. Filed Jan 27 1916
J H Coughlan
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1916, to Jan 26 1916, that I last saw her alive on Jan 26 1916 and that death occured on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinomal Meningitis

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 28 ds.

(Signed) J. R. Morgan M. D.

1-26 1916 (Address) Twin Falls per E Bowers Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Montaugh Ida. DATE OF BURIAL: Jan 27 1916

20. UNDERTAKER: J Crosby ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 13821
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME D. M. Kunkely Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Jan. (Month) 27nd (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 11 da. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Twin Falls Ida.

10. NAME OF FATHER D. M. Kunkely.

11. BIRTHPLACE OF FATHER (State or Country) Denver Colo.

12. MAIDEN NAME OF MOTHER M. E. Baden.

13. BIRTHPLACE OF MOTHER (State or Country) Helena Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D M Kunkely.
(Address) 534 8 ave East

15. Filed 1-24 1916 John F Loughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
1 (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/22/ 1916, to 1/24/ 1916, that I last saw him alive on 1/23/ 1916, and that death occured on the date stated above, at 8 9 M.

The CAUSE OF DEATH* was as follows:
Convulsions probably due to Cerebral Hemorrhage
(Duration) ..... Yrs. ..... mos. 1/2 ds.
Contributory (Secondary) Complications in labor
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W. F. Pike M. D.
1/24/1916 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Jan 14th 1916

20. UNDERTAKER: Goodman & Jones — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 37

Primary Registration District No. 1055

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13822

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of ..... (If death occurs away from usual residence, give facts called for under special information.)

2. FULL NAME Ernest Geo. Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb 14 (Month) (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Twin Falls

10. NAME OF FATHER E. N. Johnson

11. BIRTHPLACE OF FATHER (State or Country) Colo

12. MAIDEN NAME OF MOTHER Emmily Manwell

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E N Johnson
(Address) T Falls

15. Filed 2-28 1916 J H Coughlan Local Registrar

SYMS - YORK CO., PYRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
2 (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/27/1916, to 2/27/1916, that I last saw him alive on 2/27/1916, and that death occured on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH*, was as follows:

Convulsions

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Congenital Heart leakage

(Duration ..... yrs.) ..... mos. 9 ds.

(Signed) W. J. Pike M. D.

2/28/1916 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 2-28 1916

20. UNDERTAKER: J Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1095
File No. 13823
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Ida Campbell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept. 26 (Month) (Day) 1846 (Year)

7. AGE 69 Yrs. 5 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Wm Brady

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Brown

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. B. Campbell
(Address) Twin Falls

15. Filed 2-28 1916 J. H. Coughlin Local Registrar

SVMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-17 1916, to 2-26 1916, that I last saw h[er] alive on 2-26 1916 and that death occured on the date stated above, at [illegible] P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular

(Duration) 10 days Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G. D. Mercer M. D.
19..... (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 2-29 1916

20. UNDERTAKER: A. J. Crowley
ADDRESS: T. F.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICAT[redacted]

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls

City of ..... "

Registration District No. .....

Primary Registration District No. 1085

(No. ....., ... St.)

File No. 13824

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Alice Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Jan 18 (Month) (Day) 1855 (Year)

7. AGE: 61 Yrs. X Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Solomon Huddleston

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Christina Myer

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elsie Williams

(Address) Twin Falls

15.

Filed 2-18 1916

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1916, to Feb 16 1916, that I last saw her alive on the 15th of Dec 1916, and that death occured on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac failure secondary to Subacute Nephritis

(Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary) Unresolved Pelvic Pneumonia (Duration ..... yrs. 2 mos. ..... ds.

(Signed) E. Orwoods M. D.

2-18 1916 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 2-20 1916

20. UNDERTAKER: Chas J Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 37

County of Twin Falls Primary Registration District No. 1085.

City of " " (No. ....., ... St.)

File No. 13825

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Bacher

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	unknown

6. DATE OF BIRTH unknown (Month) 1 (Day) ..... (Year)

7. AGE ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. ed 2-3 1916 John W Langdon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 2 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Necropsy. Fatty-heart- myocardeis, valvular heart disease. Found dead in bed.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F Coughlan M. D.
2-3 1916 (Address) T Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL T Falls

DATE OF BURIAL 2-7 1916

20. UNDERTAKER C. J. Crosby

ADDRESS T Falls

Item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

...RK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 7095
File No. 13826
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Luberta Bowles

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. October 21st 1877 (Month) (Day) (Year)

7. AGE: 39 Yrs. 3 Mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: David Bancroft

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Reidenbaugh

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): S E Bowles
(Address): Twin Falls

15.
Filed 1-25 1916
J F Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1916, to 1-20 1916, that I last saw her alive on Jan 20 1916, and that death occured on the date stated above, at 11.30 P.M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of the Stomach
(Duration) Yrs. ..... mos. 5 ds.
Contributory (Secondary) Cholecystotomy - for Gall Stones and Cystic Gall Bladder
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Morgan M. D.
1-25 1916 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls DATE OF BURIAL: Jan 23 1916

20. UNDERTAKER: C. J. Crosby ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 13827
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louise Ida Porter
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct 10 (Month) (Day) 1870 (Year)

7. AGE 46 Yrs. 3 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Was teacher 6 yrs ago

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Jas. B. Porter

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Josephine Ide

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Helen D. Porter
(Address) Twin Falls

15. Filed 1-15 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
1 (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-11 1916, to 1-14 1916, that I last saw h[illegible] alive on 1-13-1916, and that death occured on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Hemiplegia
Hemorrhage in Bulbar region
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Second Stroke
(Duration ..... yrs. ..... mos. 7 ds.
(Signed) J. R. Morgan M. D.
1-14 1916 (Address) Twin Falls Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Jan 15 1916

20. UNDERTAKER: C. J. Crosby — ADDRESS: Twin Falls

SVMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls — Registration District No. 37

City of " " — Primary Registration District No. 1085 — File No. 13828

(No. ....., ... St.) — Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Henry Gerboth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June 20 1899 (Month) (Day) (Year)

7. AGE: 17 Yrs. 6 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Nevada

10. NAME OF FATHER: Chas. W Gerboth

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Ida Parkison

13. BIRTHPLACE OF MOTHER (State or Country): Nevada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas W. Gerboth
(Address) Jerome Ida
Jan 12 1916

15.
Filed 1-12 1916 — John R Coughlan, Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 8 1916, to Jan 12 1916, that I last saw h.. alive on Jan 12 1916, and that death occured on the date stated above, at 7 am M.

The CAUSE OF DEATH* was as follows:
Intestinal obstruction

..... (Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H W Wilson M. D.
(Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome — DATE OF BURIAL: Jan. 14 1916

20. UNDERTAKER: Foreman & Ewer — ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 13829
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sara Jane Kline

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April 7th 1881
(Month) (Day) (Year)

7. AGE: 35 Yrs. 8 Mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Benedict Middleton

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Sarah Jane Aldere

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Millicent Middleton
(Address) Rogerson Idaho

15.
Filed 1-16 191 6 John R. Coughlin Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24668

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
1 (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2d 1916, to Jan 6th 1916, that I last saw h.. alive on Jan 6th 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Puerperal Septicemia
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Abortion,
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W. H. Vik M. D.
1/7/1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Jan 9 1916

20. UNDERTAKER: Chas J Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13830
Registered No. .....

Registration District No. 37
Primary Registration District No. 1089
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Twin Falls
City of " "

2. FULL NAME Lawrence N. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. 28 (Month) (Day) 1890 (Year)

7. AGE: 25 Yrs. 10 Mos. 6 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Horse dealer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Neb.

10. NAME OF FATHER G. N. Smith

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Nila L. Berry

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. N. Smith
(Address) Twin Falls Ida

15. Filed 1-3 1916
J. W. Coughran
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 3rd (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17th 1915, to Jan 3rd 1916., that I last saw him alive on Jan 3rd 1916, and that death occured on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

.....(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Typhoid Fever

.....(Duration ..... yrs. 4 mos. 17 ds.

(Signed) Duncan L. Strandberg M. D.

1/4 1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Jan 5 1916

20. UNDERTAKER: O. J. Crosby — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13832

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Cassia
City of Albion
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME David Hilliard Bennett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 7 (Day) 1847 (Year)

7. AGE: 69 yrs. mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Shoe Maker
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): New Jersey

10. NAME OF FATHER: Moses H Bennett

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Lucy Reamer

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Logan Bennett
(Address) Albion

15.
Filed Jan 21 1916 R H Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1915, to Jan 19 1916, that I last saw h[illegible] alive on at Same 191, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Heart Leakage & dropsy

(Duration) Dont Know mos. ds.
Contributory (Secondary) Some trouble in stomach perhaps Cancer
(Duration) 2 yrs 3 mos ds.

(Signed) R. H. Greene M. D.
Jan 21 1916. (Address) ~~R H Greene~~ Albion

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Albion Cemetery — DATE OF BURIAL: Jan 21 1916

20. UNDERTAKER: Walter Powell — ADDRESS: Albion

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statment of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13834

Registered No. .....

1. PLACE OF DEATH.

County of Boundary — Registration District No. 79.

City of Bonners Ferry (No. ..... St.) — Primary Registration District No. 7186.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leonard Bone's Baby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED~~, ~~WIDOWED OR DIVORCED~~. (Write the word.)

6. DATE OF BIRTH: February (Month) 7th (Day) 1916 (Year)

7. AGE: ..... Yrs. ..... Mos. 12 Hours

IF LESS than 1 day how many 12 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bonners Ferry Ida

10. NAME OF FATHER Leonard Bone

11. BIRTHPLACE OF FATHER (State or Country) Michigan

12. MAIDEN NAME OF MOTHER Mona Brisier

13. BIRTHPLACE OF MOTHER (State or Country) Chewy Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Leonard Bone
(Address) Bonners Ferry Ida

15. Filed Feb. 8th 1916. E.E. Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 1916, that I last saw h-er alive on ..... 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Atelectasis

.....(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

.....(Duration — yrs. — mos. — ds.

(Signed) L. W. Bassett M. D.

2/8 1916 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Bonners Ferry Ida — DATE OF BURIAL: 2/8 1916

20. UNDERTAKER: L. T. Moore — ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13835

Registered No. .....

1. PLACE OF DEATH.

County of Bonneville Registration District No. 79.

City of Bonneville Ferry Ada, ... St.) Primary Registration District No. 216.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George C Schofield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 7 (Day) 1852 (Year)

7. AGE 63 Yrs. 8 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Charles Schofield

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Nancy Terry

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E C Hess

(Address) Bonneville Ferry Ada

15. Filed Mar. 14 1916. E E Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 13th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 7 1916, to Mar. 13 1916., that I last saw him alive on Mar. 13 1916., and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry, M. D.

3/14 1916. (Address) Bonneville Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonneville Ferry Ada — DATE OF BURIAL: 3/15 1916

20. UNDERTAKER: John D Moore — ADDRESS: Bonneville Ferry Ada

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13836

Registered No. .....

1. PLACE OF DEATH

County of Lemhi — Registration District No. 79.

City of Lemhi Ferry (Ward) ..... St.) — Primary Registration District No. 216.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William S. Purdy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: 3 (Month) 24 (Day) 1865 (Year)

7. AGE: 50 Yrs. 11 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Station Engineer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE: Near Harrisonville
(State or Country) Scioto Co Ohio

10. NAME OF FATHER: William

11. BIRTHPLACE OF FATHER
(State or Country) Scioto Co Ohio

12. MAIDEN NAME OF MOTHER: Jane Bennett

13. BIRTHPLACE OF MOTHER
(State or Country) Scioto Co Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alonzo E Purdy
(Address) Lucasville

15. Filed Mar. 20th 1916. E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 10th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 4 1916, to Mar. 9 1916, that I last saw him alive on Mar. 9 1916, and that death occured on the date stated above, at 11.30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) Lemhi Ferry Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 6 days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? Port Hill, Ida.

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Lucasville Ohio — DATE OF BURIAL: 11 1916

20. UNDERTAKER: John T. Mann — ADDRESS: Lemhi Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79.
Primary Registration District No. 2156.
(No. ....., ... St.)

File No. 13837
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Beechley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 78 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): —

10. NAME OF FATHER: DeWitt

11. BIRTHPLACE OF FATHER (State or Country): — — —

12. MAIDEN NAME OF MOTHER: — — —

13. BIRTHPLACE OF MOTHER (State or Country): — — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. C. Nichols
(Address) Canyon County Idaho

15. Filed Feb. 21 - 1916. E E Fry
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February 20th 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18 - 1916, to Feb. 20 - 1916., that I last saw her alive on Feb. 20 - 1916., and that death occured on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

2/21/1916. (Address) Canyon County Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon County Idaho
DATE OF BURIAL: 2/22 1916.

20. UNDERTAKER: John T. Moore
ADDRESS: Canyon County Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13838

Registered No. .....

Registration District No. 79.

Primary Registration District No. 3156.

(No. .... St.)

1. PLACE OF DEATH.

County of Boundary

City of Bonners Ferry

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Adelia Hergig

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 19 (Day) 1846 (Year)

7. AGE ..... Yrs. 66 Mos. 9 ds. 5

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Anton Mitsch

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Anna Kobek

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Hergig

(Address) Bonners Ferry

15. Filed Jan. 25 - 1916. E. E. Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 24th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 21 1916, to Jan. 24 1916, that I last saw h[illegible] alive on Jan. 24 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

..... (Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Fry M. D.

1/25 1916. (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida

DATE OF BURIAL: 1/27 1916

20. UNDERTAKER: John D. Moore

ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79.
Primary Registration District No. 3156.
File No. 13839
Registered No. .....

1. PLACE OF DEATH.
County of Boundary
City of ..... (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information. Addie, Ida.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Francis Gillon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.)

6. DATE OF BIRTH. November 16th 1863 (Month) (Day) (Year)

7. AGE: 52 Yrs. 2 Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER — I

11. BIRTHPLACE OF FATHER — (State or Country) Ireland

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs James F Gillon
(Address) Addie Idaho

15. Filed Jan 18th 1916. E. E. Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 17th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1913, to Jan. 17- 1916, that I last saw him alive on Dec. 30th 1915, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach -
(Cardiac End)

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Fry M. D.
1/18 1916 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida. DATE OF BURIAL: Jan 22 1916

20. UNDERTAKER: Geo. J. Moore ADDRESS: Bonners Ferry Ida

BYHS - YORK CO., PTRS. & BOBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13840

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonner Registration District No. 39

City of Bonners Ferry (Ward ....., ... St.) Primary Registration District No. 315.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mike Casey.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 1 (Day) ..... (Year)

7. AGE: 50 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: John Casey

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Johanna Casey
(Address) Bonners Ferry Ida

15. Filed Jan 13 1916 E. E. Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 10th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:
Accidental Suffocation

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Fry M. D.

1-13 1916. (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Bellepaine, Mont. | DATE OF BURIAL: 1-17 1916

20. UNDERTAKER: John T. Moore | ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79.
Primary Registration District No. 218-6

File No. 13841
Registered No.

1. PLACE OF DEATH.
County of Boundary
City of Lenia Ida (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME C. W. Gillespie

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 27 (Day) 1852 (Year)

7. AGE: 64 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry business, or establishment in which employed (or employer): Farm

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Robert Gillespie

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bertie Gillespie
(Address) Lenia Idaho

15. Filed Jan. 6th 1916. E. W. Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 5 1916, to The one visit 191..., that I last saw him alive on January 5 1916, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Paralysis

..... (Duration) ..... yrs. ..... mos. One ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. English M. D.
Jan 7 1916 (Address) Troy Mont

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL: Jan 8 1916

20. UNDERTAKER: Smith & Co — ADDRESS: Spokane Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13842

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Boundary

City of Bonners Ferry (No. ....., ... St.)

Registration District No. 79.

Primary Registration District No. 3186.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Earl Jacoby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 29 (Day) 1915 (Year)

7. AGE ..... Yrs. ..... Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Joseph A Jacoby

11. BIRTHPLACE OF FATHER (State or Country) Minnesota

12. MAIDEN NAME OF MOTHER Mabel V. Chapman

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph A. Jacoby.

(Address) Bonners Ferry Ida.

15. Filed Jan. 2nd 1916 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 29 1916, to Jan. 1st 1916, that I last saw him alive on Dec. 31 1916, and that death occured on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

Convulsions

..... (Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D

1/2 1916. (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida. DATE OF BURIAL: 1/3 1916

20. UNDERTAKER: John T Moore ADDRESS: Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 99

County of Fremont

Primary Registration District No. 7 (7)

City of St Anthony

(No. ....., ... St.)

File No. 13846

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Not named

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH: Feby (Month) 28 (Day) 1916 (Year)

7. AGE: ..... yrs. mos 1 ds.

IF LESS than 1 day how many ..... hrs. or 75 ... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: D. W. Morris

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Ida Pemberton

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. R. Pemberton
(Address) St Anthony Ida

15. Filed Mar 191.. W. A. Wert Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar 1st 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 24 1916, to Mar 1st 1916 that I last saw him alive on Feby 29 1916, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows: Premature birth (6 Mons)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Wert M. D.

Mar 1st 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Anthony | DATE OF BURIAL: Mar 1st 1916

20. UNDERTAKER: None | ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13849
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St Anthony (No. 6, St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 217

2. FULL NAME Fred Lawrence Kinney

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: November 3rd 1843
(Month) (Day) (Year)

7. AGE: 71 yrs. 2 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Attorney
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York State

10. NAME OF FATHER: Jacob Kinney

11. BIRTHPLACE OF FATHER (State or Country): New York State

12. MAIDEN NAME OF MOTHER: Katherine Mead

13. BIRTHPLACE OF MOTHER (State or Country): New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ina Wilcox
(Address) St Anthony Idaho

15.
Filed Mch 10 1916 W D Lovell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 1 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 29th 1916, to Feb 1st 1916, that I last saw him alive on Feb 1st 1916, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary): Heart Failure (Mitral Stenosis)

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) R. Eby M. D.
Feb 3rd 1916 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby Ida
DATE OF BURIAL: Feb 5th 1916

20. UNDERTAKER: W D Lyons
ADDRESS: St Anthony

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 99

Primary Registration District No. 177

File No. 13850

County of Fremont

City of St Anthony (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lexie Lamb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

Aug (Month) 26 (Day) 1884 (Year)

7. AGE 31 yrs. 5 mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER J W Lamb

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mercy Emma Haynes

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred W Lamb Jr.

(Address) Eureka Utah

15.

Filed Feby 26 1916 W B Wood
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feby (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 22 1916 to Feby 24 1916 that I last saw h.. alive on Feby 24 1916 and that death occurred on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) Appendicitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W B Wood M. D.

Feby 26 1916 (Address) St Anthony Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Anthony	Feby 26 1916

20. UNDERTAKER	ADDRESS
W D Gayer	St Anthony

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13851

Registered No.

1. PLACE OF DEATH.

Registration District No.

County of Kootenai

Primary Registration District No.

City of Spirit Lake. (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Mary A Mann 3rd Ave.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: May (Month) 19 (Day) 1842 (Year)

7. AGE: 73 yrs. 9 mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Pardon Sherman

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Molly D. Park

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. A. Thompson

(Address) Spirit Lake, Idaho

15. Filed Mar 5 1916 Stacy Maxwell Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 3 1916, to Mar 4 1916, that I last saw h[er] alive on Mar 4 1916, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(Duration) yrs. mos. 2 ds.

Contributory (Secondary) Senile debility

(Duration) yrs. mos. ds.

(Signed) Edward O Brindley M. D.

3-5 1916 (Address) Spirit Lake Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence Duluth, Minnesota

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn. DATE OF BURIAL: 191...

20. UNDERTAKER: O. W. Stone ADDRESS: Rathdrum Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13853

Registered No. .....

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

County of .....

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ole Olesen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. ~~SINGLE, MARRIED, WIDOWED OR~~ DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1853 (Year)

7. AGE: 63 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Mill Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweeden

10. NAME OF FATHER Couldant get other data

11. BIRTHPLACE OF FATHER — (State or Country)

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER — (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthur Russell

(Address) Spirit Lake

15. Filed 3/20 1916 Chas J Mercier Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 18 1916, to Mar 19 1916, that I last saw him alive on Mar 19 1916, and that death occured on the date stated above, at 12 45 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(Duration) ..... Yrs. ..... mos. 1 day

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Earle A Priest M. D.

3-20 1916 (Address) Spirit Lake Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Calfox Wash — DATE OF BURIAL: March 20 1916

20. UNDERTAKER: O. W. Storm — ADDRESS: Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13854

Registered No. 16

1. PLACE OF DEATH.

County of Bannock

City of .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Not ~~Venona~~ Venona Densley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. (Month) 22 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 12 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: I. J. Densley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mobleta Bens

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) I. J. Densley

(Address) Soda Springs

15. Filed Feb 10, 1916 Lees Nancy, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 22 1916, to Feb. 22 1916, that I last saw h~~e~~r alive on Feb. 22 1916, and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Russell Tight, M. D.

2/23 1916 (Address) Soda Springs.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Soda Springs, Idaho — DATE OF BURIAL: Feb 24 1916

20. UNDERTAKER: Nave — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13857

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 106

Primary Registration District No. 2184

County of Idaho

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank P Turner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: A. J. Turner

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wilmot Turner
(Address) Kooskia - Idaho

15.
Filed Feb 3 1916 Jm. Vetterkuse
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1916, to Feb 1 1916
that I last saw him alive on Jan 31 1916,
and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:
Cancerous of Stomach

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Endocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J.M. Vetterkuse M. D.
Feb 3 1916 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Private Cemetery near Newland Ranch

DATE OF BURIAL: Feb 3 1916

20. UNDERTAKER: Rev. Eastman (Pastor)

ADDRESS: Stite Idaho.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13884

Registered No. .....

1. PLACE OF DEATH.

County of Teton

City of Victor

Registration District No. 70

Primary Registration District No. 2612

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mechalina Palagi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.

2 (Month) 4 (Day) 1896 (Year)

7. AGE

19 Yrs. 1 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Joe Plostino

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Victoria Magnone

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Palagi

(Address) Victor Idaho

15. Filed 3-21 1916

Geo D Thacker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7 1916, to March 20 1916, that I last saw h er alive on March 20 1916 and that death occured on the date stated above, at 3:40 a M.

The CAUSE OF DEATH* was as follows:

Pneumonia Septicemia

(Duration) — Yrs. — mos. 7 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ben. F. Newman M. D.

3-21 1916 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Victor Idaho

DATE OF BURIAL ..... 191.....

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8
Primary Registration District No. 2005
(No. ....., ... St.)

File No. 13887
Registered No. 23
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Harry L. Frank

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Apr. (Month) 20 (Day) 1879 (1879) (Year)

7. AGE: 36 yrs. 10 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: book keeper
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Nelson Frank

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Margaith Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter S. Siebold.
(Address) Caldwell, Ida.

15.
Filed 3-15- 1916 John L. Meyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13 1916, to March 13 1916, that I last saw him alive on March 13 1916, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of heart with valvular lesion
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Nervous breakdown some years ago.
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S. J. Mellen M. D.
3-16- 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: Mar. 16 1916

20. UNDERTAKER: Beckham Case Co. ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16672

FORM V. S. No. 6-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13888

Registered No. 34

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Greenleaf.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 20025

(No. ....., ... St.)

2. FULL NAME Cora B. Beals.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.

6. DATE OF BIRTH. June (Month) 14 (Day) 1869 (Year)

7. AGE: 46 Yrs. 9 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House wife.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa.

10. NAME OF FATHER Arthur Bufkin.

11. BIRTHPLACE OF FATHER (State or Country) Indianna.

12. MAIDEN NAME OF MOTHER Mattie Macy.

13. BIRTHPLACE OF MOTHER (State or Country) Indianna.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. F. Beals
(Address) Greenleaf Ida.

15.
Filed 3-16- 1916
John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1914, to March 16, 1916, that I last saw her alive on March 5 1916 and that death occured on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis & Cancer

(Duration) 1 Yrs. 6 mos. ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Beals M. D.
3/16 1916 (Address) Greenleaf Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Greenleaf — DATE OF BURIAL Mar. 17 1916

20. UNDERTAKER Beckham Case Co — ADDRESS Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1003
File No. 13889
Registered No. 25

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harriet C Phillips

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. Mar (Month) 15 (Day) 1830 (Year)
7. AGE: 8 6 Yrs. ..... Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Tenn
10. NAME OF FATHER: John Hunter
11. BIRTHPLACE OF FATHER (State or Country): Dont Know
12. MAIDEN NAME OF MOTHER: Martha Self
13. BIRTHPLACE OF MOTHER (State or Country): Tenn
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Vasta Jensen
(Address) Caldwell Ida.
15. Filed 3-22- 1916 Joel D Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 7 (Month) (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 10 1915 to Mar 21 1916, that I last saw h[illegible] alive on Mar 21 1916, and that death occured on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:
Old age,
Chronic Endocarditis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J W Foster M. D.
3/22 1916 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 3/22 1916
20. UNDERTAKER: W E Dye
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. ..... St.)

File No. 13890
Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City or Circuit Farm

2. FULL NAME David Blair

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Don't Know

6. DATE OF BIRTH.
Don't Know (Month) ..... (Day) 1839 (Year)

7. AGE
Don't Know Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Don't Know

10. NAME OF FATHER
—

11. BIRTHPLACE OF FATHER
(State or Country) — —

12. MAIDEN NAME OF MOTHER
—

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. A. Farris
(Address) Caldwell Ida.

15.
Filed Mar. 30 1916
John L. Meyer
Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 21 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1916, to Mar 21 1916, that I last saw him alive on Mar 19 1916, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Cancer of Liver
.....
.....
.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary)
.....(Duration) .....yrs. .....mos. .....ds.

(Signed) A. D. Farris, M. D.
3/22 1916 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Mar 30 1916

20. UNDERTAKER: W. E. Dyer — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-2[illegible] 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 7005

File No. 13891

Registered No. 27

County of Canyon

City of Caldwell (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Isaac J. Beales

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. (Month) Aug. (Day) 14. 1857

7. AGE: 58 Yrs. 11 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Rancher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Thos. Beales.

11. BIRTHPLACE OF FATHER (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Elizabeth Beales

13. BIRTHPLACE OF MOTHER (State or Country) Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Prescott L. Beals
(Address) Greenleaf, Idaho

15. Filed 3-29- 1916 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Mar (Day) 27 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16 1916, to March 27 1916, that I last saw him alive on March 27 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Pleuro Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) L. J. Miller M. D.

3-29-1916 (Address) Caldwell Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greenleaf — DATE OF BURIAL: Mar 30 1916

20. UNDERTAKER: Peckham Co. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2605
(No. ..... St.)

File No. 13892
Registered No. 28

1. PLACE OF DEATH.

County of Benewah
City of Notus

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Asa Orlando McKinley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 22 (Day) 1826 (Year)

7. AGE: 89 Yrs. 11 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): State of New York

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Earl Wallford
(Address) Notus Idaho

15. Filed May 31 1916 — John L. Meyers, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 29" 1916, to Mar. 29" 1916, that I last saw him alive on Mar. 29" 1916, and that death occured on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

General Debility

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) —

(Duration — yrs. ..... mos. ..... ds.

(Signed) J. M. Kuns M. D.
May 31" 1916 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lower Boise — DATE OF BURIAL: 5/31 1916

20. UNDERTAKER: W. A. Dyer — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13893

Registered No. 29

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

(No. ..... St.)

Registration District No. 3

Primary Registration District No. 1005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Summers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. July (Month) 30 (Day) 1847 (Year)

7. AGE: 68 Yrs. 9 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois Iowa

10. NAME OF FATHER: Coombs.

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: — —

13. BIRTHPLACE OF MOTHER (State or Country): — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. H. Haynes

(Address) Caldwell Idaho

15. Filed 4-3-1916 Jos. S. Meyer. Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25 1916, to April 1st 1916, that I last saw h.E.r alive on April 1st 1916, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Chronic Dysentery

(Duration) 4 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) J. L. Farmer, M. D.

4/3 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Wahoo Nebraska

DATE OF BURIAL: 4/3 1916

20. UNDERTAKER: W. L. Dyer

ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13894

Registered No. 30

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information. Rural.

Registration District No. 3

Primary Registration District No. 2005

(No. ..... St.)

2. FULL NAME Mary Ann Jones.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH. Oct. (Month) 18 (Day) 1835 (Year)

7. AGE 80 Yrs. 6 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Edward Upton

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Dorothy Sparrow

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs E E Perry
(Address) Caldwell Idaho R.F.D. 4

15. Filed 4-5 1916 John S. Mayes. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 31 1916, to April 4 1916, that I last saw her alive on Mar. 31 1916 and that death occured on the date stated above, at 5.45 P. M.

The CAUSE OF DEATH* was as follows:

Senile Debility

(Duration) 6 Yrs. mos. ds.

Contributory (Secondary) Senile Gangrene ulcers

(Duration yrs. 1 mos. ds.

(Signed) C. M. Tracy M. D.

4-5 1916 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	April 5 1916
20. UNDERTAKER W C Dyer	ADDRESS Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 13895
Registered No. 37

1. PLACE OF DEATH.
County of Canyon
City of Caldwell.
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William A. Murry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. October (Month) ..... (Day) 1878 (Year)

7. AGE: 38 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Don't Know

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas Wright
(Address) Caldwell R. 3. #31

15. Filed 4-7-1916 John S. Meyer, Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1916, to April 6 1916, that I last saw h~~im~~ alive on April 6 1916, and that death occured on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Cole M. D.
4/7 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Canyon Hill — DATE OF BURIAL: 4/7 1916

20. UNDERTAKER: W. S. Dyer — ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia

City of Jackson

Registration District No. 19

Primary Registration District No. 2015

(No. ....., ... St.)

File No. 13897

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Williams Orr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct 31 (Month) (Day) 1914 (Year)

7. AGE: 1 Yrs. 5 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jackson Ida.

10. NAME OF FATHER: Robt B Orr

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Agnes Wright

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father

(Address) Jackson Ida

15. Filed 4—7 1916 E H Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 25 1916, to April 2 1916, that I last saw h[illegible] alive on April 2 1916, and that death occured on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J B Kennedy M. D.

1916 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jackson

DATE OF BURIAL: Apr 3 1916

20. UNDERTAKER: J. R. Throckmorton

ADDRESS: Rupert Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 11 13898

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117

Primary Registration District No. .....

(No. ....., ... St.)

2. FULL NAME Sarah Jane Phillips

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married

6. DATE OF BIRTH. Mar (Month) 6 (Day) 1862 (Year)

7. AGE: 54 Yrs. 0 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Levi Jones

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Emily Taylor

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Craycroft

(Address) Burley

15. Filed March 19th 1916. Dr. J. C. Patterson, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24852

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/1 — 1916, to 3/16 — 1916, that I last saw h[er] alive on 3/16 — 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebral - Hemorrhage

(Duration) — Yrs. — mos. 18 ds.

Contributory (Secondary) Chronic Nephritis

(Duration 3 yrs. — mos. — ds.

(Signed) W. A. Cooper M. D.

19.... (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida

DATE OF BURIAL: 3/20 1916

20. UNDERTAKER: Newvatt # 150

ADDRESS: Burley Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of

Primary Registration District No. 2153

File No. 13899

City of

(No. , St.)

Registered No. 872

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa Ewing

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH

(Month) (Day) 1869 (Year)

7. AGE

47 yrs. mos. ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE West Virginia
(State or Country)

10. NAME OF FATHER John W Ewing

11. BIRTHPLACE OF FATHER West Virginia
(State or Country)

12. MAIDEN NAME OF MOTHER Carline Frame

13. BIRTHPLACE OF MOTHER West Virginia
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. F. Ewing

(Address)

15.

Filed March 23 1916 M M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 12 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8 1916, to March 12 1916, that I last saw her alive on March 12 1916, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) yrs. mos. ds.

Contributory Grip
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M M McKinnon M. D.

March 13 1916 (Address) Lapwai

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lapwai	March 15 1916
20. UNDERTAKER	**ADDRESS**
E. H. Brown	Lapwai

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13900
Registered No. 873

1. PLACE OF DEATH.
County of Bonner
City of Sachse

Registration District No. 78
Primary Registration District No. 2155
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Christianson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W.	Singl

6. DATE OF BIRTH: Feb. (Month) 17 (Day) 1913 (Year)

7. AGE: 3 yrs. mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Sachse

10. NAME OF FATHER Hans P. Christianson

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Engel Halvorson

13. BIRTHPLACE OF MOTHER (State or Country) Spokane Washn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. P. Dunfee
(Address) Sachse

15. Filed March 13 1916 W. W. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 9 1916, to Mch 11 1916
that I last saw her alive on Mch 11 1916
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:

Cerebro spinal meningitis

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. N. Williams M. D.
Mch 14 1916 (Address) Sachse Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sachse	Mch 14 1916

20. UNDERTAKER	ADDRESS
E. M. Brower	Sandpoint Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13901

Registration District No. 78

Primary Registration District No. 2155

Registered No. 874

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria Mathilda Kujawski.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Jan. (Month) 9 (Day) 1848 (Year)

7. AGE: 68 yrs. 2 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Grosbotschingen Germany Kreis Thorn

10. NAME OF FATHER David Fraser.

11. BIRTHPLACE OF FATHER (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Barbara Wilhelmina

13. BIRTHPLACE OF MOTHER (State or Country) Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Phil. Wille
(Address) Sandpoint Idaho

15. Filed March 13 1916 W. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1916, to March 13 1916, that I last saw her alive on March 12 1916, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. McKinnon M. D.
March 14 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho — DATE OF BURIAL: March 15 1916

20. UNDERTAKER: C. Anderson — ADDRESS: Sandpoint

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2153

File No. 13902

County of Bonner

City of Sandpoint (No. ....., ... St.)

Registered No. 873

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsie Hawkins

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	single

6. DATE OF BIRTH

Mar 29 1913
(Month) (Day) (Year)

7. AGE

2 yrs. 11 mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE

(State or Country) Butte Mont

10. NAME OF FATHER Geo Hawkins

11. BIRTHPLACE OF FATHER

(State or Country) Finland

12. MAIDEN NAME OF MOTHER Anna Smith

13. BIRTHPLACE OF MOTHER

(State or Country) Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Hawkins

(Address) Kootenai Ida

15.

Filed March 19 1914 W M Knapp
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 18 1914
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Paralysis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W M Knapp M. D.

19 (Address) Hope Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint	Mar 21 1914
20. UNDERTAKER	**ADDRESS**
E M Brown	S P.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13903
Registered No.

1. PLACE OF DEATH. Registration District No. 105
County of Idaho Primary Registration District No. 2183
City of Cottonwood (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion Gilbertson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Femal
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Dec (Month) 2 (Day) 1843 (Year)

7. AGE: 75 yrs. 2 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: ? Erickson

11. BIRTHPLACE OF FATHER (State or Country): Norway Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. Asker
(Address) Cottonwood

15.
Filed Mch 2nd 1916 H Bohrer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March. (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 29th, 1916, to Mch. 1st, 1916
that I last saw h[illegible] alive on Mch. 1st, 1916
and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Intestinal Obstruction from Strangulated Hernia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Turner, M. D.
Mch. 2nd 1916 (Address) Cottonwood, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cottonwood
DATE OF BURIAL: May 3 1916

20. UNDERTAKER: A. J. Maugg
ADDRESS: Cottonwood

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13904
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Greencreek (No. ....., ... St.)

Registration District No. 105
Primary Registration District No. 2183

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary K Nuxoll

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: March (Month) eleven (Day) 1874 (Year)

7. AGE: 41 yrs. 11 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: house wife farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Frank Beckman

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Catherina Wilenborg

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John F Nuxoll
(Address) Greencreek Idaho.

15.
Filed March 3 1916 H Wobbe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 29 1916, to May 2 1916 that I last saw h er alive on May 2nd 1916 and that death occurred on the date stated above, at 12:00 M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.
Contributory (Secondary) Asthma and Bronchitis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Wesley F. Orr M. D.
May 3rd 1916 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Greencreek
DATE OF BURIAL: May 4 1916

20. UNDERTAKER: A. J. Mauzy
ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8 13905

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 105

Primary Registration District No. 2103

County of Idaho

City of Greencreek (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josef Schmidt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH: Nov. (Month) 1 (Day) 1864 (Year)

7. AGE: 51 yrs. 7 mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Greencreek, Ida.

10. NAME OF FATHER: Gerhard Schmidt

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Bernardina Witthorn

13. BIRTHPLACE OF MOTHER (State or Country): Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank W. Mapes
(Address) COTTONWOOD, IDAHO

15. Filed March 15 1916 W Boles Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 13th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch. 12th 1916, to Mch. 13th 1916, that I last saw him alive on Mch. 13th 1916, and that death occurred on the date stated above, at 4 30 P.M.

The CAUSE OF DEATH* was as follows: Cerebral abscess following Otitis Media purulenta.

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... mos. ..... ds.

(Signed) J. H. Turner M. D.

Mch. 15, 1916 (Address) Cottonwood, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greencreek — DATE OF BURIAL: Mar. 16 1916

20. UNDERTAKER: E. S. Hancock — ADDRESS: Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13906

Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Ferdinand (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183

2. FULL NAME John H Uhlorn

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: July 24 (Month) (Day) 1848 (Year)

7. AGE: 67 yrs. 8 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: John Uhlorn

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Bernidina Withorn

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mary E. Uhlorn
(Address): Ferdinand Idaho

15.
Filed Mch 22 1916 H Bolen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14th, 1916, to March 21st, 1916 that I last saw him alive on Mch. 21st, 1916., and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 8 ds.

Contributory (Secondary): Chronic Valvular heart-disease

(Duration) Indefinite yrs. mos. ds.

(Signed) J. W. Turner M. D.
Mch. 22, 1916 (Address) Cottonwood, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ferdinand Cemetery
DATE OF BURIAL: March 23 1916

20. UNDERTAKER: A. J. Maugg
ADDRESS: Cottonwood Ida.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.....
Primary Registration District No.....
(No. ....., ... St.)

File No. 9
Registered No. 13907

1. PLACE OF DEATH.

County of Gem
City of Ola

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Theresa May Young

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 26 (Day) 1915 (Year)

7. AGE ..... Yrs. ..... Mos. 9 ds. 15

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farming
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Walter Blane Young.

11. BIRTHPLACE OF FATHER (State or Country) Kansas.

12. MAIDEN NAME OF MOTHER Theresa May Breshears

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Theresa may Young
(Address) Ola, Idaho.

15. Filed Feb 11 1916 E Vadney Local Registrar

BYNS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb -9- 1916, to Feb 11 1916, that I last saw him alive on Feb -9- 1916, and that death occured on the date stated above, at 6.4 M.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage
of the Bowels

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E Vadney M. D.
2-11 1916. (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Ola Idaho

19. PLACE OF BURIAL OR REMOVAL Ola — DATE OF BURIAL Feb. 11 1916

20. UNDERTAKER Walker Grocery ADDRESS Ola

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13908

Registered No.

1. PLACE OF DEATH.

County of Adams

City of Indian Valley (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Edward Bennett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: July (Month) 7 (Day) 1915 (Year)

7. AGE: yrs. 6 mos. 30 ds.

IF LESS than 1 day how many ..... *hrs.* or ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Indian Valley Ida

10. NAME OF FATHER Albert Bennett

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Catherine Ensign

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas T Bennett
(Address) Indian Valley

15. Filed 5/11/16 191 R H Whiteman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191 ..., to February 7, 1916 191 ..., that I last saw him alive on ..... 191 ..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Enlarged Thymus: Death is said to have occurred at 12:00 M. 2/6/16: autopsy performed by coroner on 2/7/16 revealed Hypertrophy of Thymus Gland.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R H Whiteman M. D.

2/8 1916 (Address) Council Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Valley Ida — DATE OF BURIAL: Feb 7 1916

20. UNDERTAKER: J A Tindelton — ADDRESS: Cambridge Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ..... St.)

File No. 13909
Registered No. 6
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel R. Fleming

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: September 11th 1848 (Month) (Day) (Year)

7. AGE: 67 yrs. 6 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: Dont know

11. BIRTHPLACE OF FATHER (State or Country): Pen

12. MAIDEN NAME OF MOTHER: Martha Mason Shropshire

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Martha Stobey (daughter)
(Address) Salmon Ida

15.
Filed Mch 15 1916 Enid D. Henderson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 13 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not treat 191, to here 191, that I last saw h— alive on — 191, and that death occurred on the date stated above, at 11.30 P. M.

The CAUSE OF DEATH* was as follows:
Myocarditis following Pneumonia,

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

3/15 1916 (Signed) C. B. Stratton M. D.
(Address) Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. ~~PLACE OF BURIAL~~ OR REMOVAL: Baker City Oregon
DATE OF BURIAL: 191

20. UNDERTAKER: W. C. Noble
ADDRESS: Salmon

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

File No. 13910
Registered No. 7
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME F C Babcock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH
Do not know (Month) 1 (Day) 70 (Year)

7. AGE
about 70 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Painter & Paperhanger
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Do not know

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER (State or Country) Do not know

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C Doebler Coroner
(Address) Salmon Idaho

15.
Filed Mch. 17 1916 Edith D. Hendon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 14th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Suicidal
with Self intent

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Doebler Coroner
3-17 1916 (Address) Salmon Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Northfork Idaho	3-18th 1916

20. UNDERTAKER	ADDRESS
W. C. Doebler	Salmon Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19750

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 13911
Registered No. 8

1. PLACE OF DEATH.
County of Lemhi
City of Salmon (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John D. Hudkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
1 Feb 9th (Month) 24 (Day) 1866 (Year)

7. AGE
50 yrs. 1 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Stage Business
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) West Virginia

10. NAME OF FATHER Noah Hudkins

11. BIRTHPLACE OF FATHER (State or Country) West Virginia

12. MAIDEN NAME OF MOTHER Matista Carland

13. BIRTHPLACE OF MOTHER (State or Country) West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Maud Hudkins
(Address) Salmon Idaho

15.
Filed Apr. 4 1916 Edith D. Hendon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April 3rd 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 30th 1916, to Apl 3rd 1916, that I last saw him alive on Apl 3rd 1916, and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:
Rupture of small intestines due to accident

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. D. Wright M. D.
4/3 1916 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Salmon Cemetery | DATE OF BURIAL 4-5" 1916

20. UNDERTAKER W. C. Hobbs | ADDRESS Salmon Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 13912
Registered No. 6

1. PLACE OF DEATH.
County of Elmore
City of Mountain Home
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Laurens Kief

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Oct (Month) – 10 (Day) 1860 (Year)
7. AGE: 55 Yrs. 5 Mos. 21 ds. (B.W.M.)
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Kilmanjla Dual
10. NAME OF FATHER: John Kief
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Bridget Flynn
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward Kief
(Address) Mountain Home, Ida.
15. Filed April 1st 1916 B.C. Walker Local Registrar

6YMS - YORK CO., PTRS. & BOKS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24 1916, to March 31 1916, that I last saw him alive on March 31 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Spotted Fever
(Duration) Yrs. mos. 8 ds.
Contributory (Secondary) Probably passage of gall stones with Rupture of duct
(Duration) yrs. mos. 1 ds.

(Signed) W L Faggin M. D.
4-1 1916 (Address) Mtn Home Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home — DATE OF BURIAL: April 2nd 1916

20. UNDERTAKER: J. M. Cowen — ADDRESS: Mountain Home Idaho

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13914
Registered No. 4

1. PLACE OF DEATH. Registration District No. 47
County of Lewis Primary Registration District No. 2124
City of Nyperce (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Tolen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Not known
6. DATE OF BIRTH: Unknown (Month) (Day) 1842 (Year)
7. AGE: 74 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Denmark
10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (State or Country): Not known
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (State or Country): Not known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John L. Kelly
(Address) Nyperce Idaho
15.
Filed 4-4 1916 J. F. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 4 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 13 1916, to April 4 1916
that I last saw h.. alive on April 4 1916
and that death occurred on the date stated above, at 7:10 M.
The CAUSE OF DEATH* was as follows:
Uraemic Poisoning
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Bright's Disease
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John L. Kelly M. D.
4/4 1916 (Address) Nyperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the Hospital State 2 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? Do not know
Former or usual residence Culdesac Idaho

19. PLACE OF BURIAL OR REMOVAL: Nyperce — DATE OF BURIAL: 4/5/1916
20. UNDERTAKER: D P Donovan — ADDRESS: Nyperce
J. R. Robertson

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13915
Registered No. 7

1. PLACE OF DEATH.
County of Lewis
City of Winchester

Registration District No. 48
Primary Registration District No. 2127
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dietrich Williamson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: August 19th 1850 (Month) (Day) (Year)
7. AGE: 65 yrs. 6 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Germany
10. NAME OF FATHER: Archibald Williamson
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Catherine Bumgartz
13. BIRTHPLACE OF MOTHER (State or Country): Germany
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs D. Williamson
(Address) Winchester
15.
Filed 3-19- 1916 Elbert M. Rogers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 17th 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Died 191..., to ..... 191.....
that I last saw h[illegible] alive on ..... 191.....
and that death occurred on the date stated above, at 1/1 A M.
The CAUSE OF DEATH* was as follows:
Apoplexy
Dropped dead while at work
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Elbert M. Rogers M. D.
3-19- 1916. (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn
DATE OF BURIAL: 3-19- 1916
20. UNDERTAKER: H. R. Merchant
ADDRESS: Clarkston Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM [redacted]. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13916

Registered No. 9

1. PLACE OF DEATH.

County of Ada.

City of .....

(No. Railroad 1½ mi. N.W. of Boise)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. .....

Primary Registration District No. .....

2. FULL NAME Thomas H. Brashears.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M.	White	Married (Write the word.)

6. DATE OF BIRTH.

Oct (Month) 11 (Day) 1844 (Year)

7. AGE

77 Yrs. 4 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9. BIRTHPLACE

(State or Country) Missouri

10. NAME OF FATHER John Brashears.

11. BIRTHPLACE OF FATHER

(State or Country) Tennessee

12. MAIDEN NAME OF MOTHER Naomi Hogg

13. BIRTHPLACE OF MOTHER

(State or Country) Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Brashears

(Address) .....

15.

Filed 2-28 1916 L B Harris Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/28 1916, to 2/28 1916, that I last saw h— alive on — 1916, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred A Tuthill M. D.

2/29 1916 (Address) Lehi

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery — DATE OF BURIAL: 1916

20. UNDERTAKER: Ada Summers Co. — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 2465 [redacted]

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 71
Primary Registration District No. 2156.
File No. 13917A
Registered No. .....

1. PLACE OF DEATH.
County of Boundary
City of Bonners Ferry
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME G. R. Huffs Child
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH.
Jan (Month) 9 (Day) 1916 (Year)

7. AGE
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 12 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER G. R. Huff.

11. BIRTHPLACE OF FATHER
(State or Country) Marceville Tenn.

12. MAIDEN NAME OF MOTHER Julia Elliff.

13. BIRTHPLACE OF MOTHER
(State or Country) Rockbridge Miss.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. R. Huff
(Address) Bonners Ferry Ida

15.
Filed April 10th 1916. E. E. Fry.
Local Registrar

BYRD - YORK CO., PTRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 10th. (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 9 - 1916, to ..... 191..., that I last saw him alive on April 9th 1916., and that death occured on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Premature Birth
(7 months ?)

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Fry, M. D.
5/11 1916. (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Bonners Ferry Ida. DATE OF BURIAL 4/11 1916.

20. UNDERTAKER John T. Moore ADDRESS Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13917

Registered No. .....

1. PLACE OF DEATH.

County of Adams

City of Meadows.

Registration District No. .....

Primary Registration District No. .....

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Stefaker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ? (Month) ? (Day) 840 (Year)

7. AGE: 76 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: H. wife.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Unascertained

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. H. Newman M. D.

(Address) N. Meadows Ida.

15. Filed 5/11/16 191.....

R. H. Newman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 20(?) (Day) 191 6. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 191..., to ~ 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) R. H. Newman M. D.

19.... (Address) N. Meadows

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meadows Ida

DATE OF BURIAL: 1/22/ 191 6

20. UNDERTAKER: —

ADDRESS: —

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 77.
Primary Registration District No. 2156.
File No. 13918A
Registered No. .....

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry (No. .... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A. R. Huff Schuld

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Apr. 9 1916 (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ½ hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bonners Ferry Ida

10. NAME OF FATHER A R Huff.

11. BIRTHPLACE OF FATHER (State or Country) Knoxville Tenn.

12. MAIDEN NAME OF MOTHER Julia Elliff

13. BIRTHPLACE OF MOTHER (State or Country) Rockbridge Miss

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A R Huff
(Address) Bonners Ferry Ida

15. Filed April 10th. 1916. E E Fry. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 9th. 1916. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 9 1916, to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth
(7 months ?)

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

5/11 1916 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: 4/11 1916

20. UNDERTAKER: John T. Moore — ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13919

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Boundary

City of Bonners Ferry

(No. ....., ... St.)

Registration District No. 39

Primary Registration District No. 3156.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa Folger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 7th (Day) 1841 (Year)

7. AGE: 75 Yrs. 11 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: McDaniel

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Jones

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Byron Hvalkof
(Address) Bonners Ferry Ida

15.
Filed Apr. 13th. 1916. E. E. Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 13th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1st 1916, to Apr. 13th 1916; that I last saw h[illegible] alive on Apr. 12th 1916, and that death occured on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 10 Yrs. mos. ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Fry M. D.
4/14 1916 (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida
DATE OF BURIAL: 4/15 1916

20. UNDERTAKER: John T. Moore
ADDRESS: Bonners Ferry Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BOBS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 19198

Registered No.

1. PLACE OF DEATH.
County of Adams
City of Council
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Alice Jane Kaufman.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March (Month) 26 (Day) 1916. (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ——
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Chas. Kaufman.

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Beulah Perkins.

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Chas. Kaufman.
(Address) Council, Ida.

15. Filed 3/7/16 191 W. H. Keenan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 27 (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/26 1916. 191, to — 191, that I last saw her alive on 3/26 1916. 191, and that death occurred on the date stated above, at 6:10 P. M.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Keenan M. D.

3/6 1916 (Address) Council, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Ida. DATE OF BURIAL: 191

20. UNDERTAKER: Post Young. ADDRESS: Council Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13920A

Registered No. .....

1. PLACE OF DEATH.

County of Custer

City of Mackay

(No. ....., ... St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ann M Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 23 (Day) 1915 (Year)

7. AGE ..... Yrs. ..... Mos. 10 ds. 7

IF LESS than 1 day how many ..... hrs. or ..... min.? —

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Mackay

10. NAME OF FATHER J. C. Harris

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Mary E Athey

13. BIRTHPLACE OF MOTHER (State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. Harris

(Address) Mackay Ida

15.

Filed Apr 25 1916

R. Marie Dias
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 25th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8th 1916, to Jan 25 1916, that I last saw her alive on April 25 1916, and that death occured on the date stated above, at 1:45 P.M.

The CAUSE OF DEATH* was as follows:

Whooping Cough

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos Baker M.D.

4/25 1916 (Address) Mackay Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mackay Id — DATE OF BURIAL: 4 26 1916

20. UNDERTAKER: J R Baker — ADDRESS: Mackay

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 13920 B
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Adams
City of Indian Valley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Price

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. April (Month) 18 (Day) 1835 (Year)

7. AGE: 80 Yrs. 10 Mos. 24 Ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Arkansas

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fred E Anderson
(Address) Indian Valley

15. Filed 5/11/16 191.... R M Anderson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/7/16 191..., to 3/13/16 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Senility
La Grippe
Arteriosclerosis.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) R M Anderson M. D.
19.... (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Valley Ida. DATE OF BURIAL: Mar 1916

20. UNDERTAKER: J A Anderson ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2153
(No. ....., ... St.)

File No. 13921A
Registered No. .....

1. PLACE OF DEATH.
County of Custer
City of Dickey
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant. Fulton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH. April (Month) 11 (Day) 1916 (Year)

7. AGE: ..... Yrs. ✓ Mos. ✓ ds. ✓
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Custer Co. Ida.

10. NAME OF FATHER Frank Fulton.

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Georgia Bascom.

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Fulton
(Address) Dickey Ida.

15.
Filed Apr 13 1916 R. Morris Rees
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 1:30 A. M.

The CAUSE OF DEATH* was as follows:
Atelectasis.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

4/11 1916 (Signed) W. A. Farell M. D.
(Address) Mackay Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL ..... 191...

20. UNDERTAKER — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Adams

City of Council

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

File No. 13921B

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Nuller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unascertained (Month) (Day) (Year)

7. AGE: 65 Yrs. + Mos. + ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... Farm Laborer

9. BIRTHPLACE (State or Country) Pennsylvania (?)

10. NAME OF FATHER Unascertained

11. BIRTHPLACE OF FATHER (State or Country) Unascertained

12. MAIDEN NAME OF MOTHER Unascertained

13. BIRTHPLACE OF MOTHER (State or Country) Unascertained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. L. Stockwell M.D.

(Address) Opsa - Idaho.

15. Filed 5/11/16 191.... P.M. Inteman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 28 1916. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation, Cardiac

(?)

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) P.M. Inteman M. D.

19.... (Address) Council Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Council Ida — DATE OF BURIAL: 3/30 1916

20. UNDERTAKER: W.H. Young — ADDRESS: Council Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13922

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Adams

City of Council

(No. ....., ... St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Shaw

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unascertained 1893
(Month) (Day) (Year)

7. AGE: 23 Yrs. ? Mos. ? ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Wm. Shaw.

11. BIRTHPLACE OF FATHER (State or Country): Unascertained

12. MAIDEN NAME OF MOTHER: Unascertained

13. BIRTHPLACE OF MOTHER (State or Country): Unascertained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. H. McLean M.D.
(Address) Council Idaho

15. Filed 5/10/16 191.....

R. H. McLean
Local Registrar

SVSB - YORK CO., PTRS. & ADDS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 27 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 25 1916, to Feb. 26 1916, that I last saw her alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute Bright's Disease

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) La Grippe

.....(Duration) 1 Yrs. ..... mos. ..... ds.

(Signed) R. H. McLean M. D.

19..... (Address) Council Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Council Ida. | DATE OF BURIAL: 2/28/16 191.....

20. UNDERTAKER: Rapp & Young | ADDRESS: Council Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 18
Primary Registration District No. 2102
(No. ....., ... St.)

File No. 13923A
Registered No. 3

1. PLACE OF DEATH.
County of Minidoka
City of Heyburn
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Isabel Benfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb (Month) 7 (Day) 1858 (Year)

7. AGE 58 Yrs. ..... Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Massachusett

10. NAME OF FATHER David J Hunt

11. BIRTHPLACE OF FATHER (State or Country) Maso

12. MAIDEN NAME OF MOTHER Hunt

13. BIRTHPLACE OF MOTHER (State or Country) Maso

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arthur Benfield
(Address) Heyburn Idaho

15. Filed Mch 10 1916 — V P Killen, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 21 1915, to Dec. 27 1916, that I last saw her alive on Feb. 16 - 1916, and that death occured on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:
Multiple Sclerosis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V P Killen M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Heyburn — DATE OF BURIAL: Feb 20 1916

20. UNDERTAKER: Goodman — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 18

Primary Registration District No. 2102

(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13924

Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Minidoka

City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Long

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married

6. DATE OF BIRTH. May (Month) 1 (Day) 1829 (Year)

7. AGE: 87 Yrs. 9 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Carolina

10. NAME OF FATHER: Wm Thomas

11. BIRTHPLACE OF FATHER (State or Country): N Carolina

12. MAIDEN NAME OF MOTHER: Annie Fletcher

13. BIRTHPLACE OF MOTHER (State or Country): N. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Wm Long

(Address): Heyburn Ida R.

15. Filed Feb. 10 1916 V. R. Kilburn Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw her alive on Dec 6th 1916 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

From the infirmities of old age.

(Duration) 87 Yrs. 9 mos. 2 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr. H. Truesdale M. D.

7-7 1916 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Heyburn Ida — DATE OF BURIAL: 7/8 1916

20. UNDERTAKER: Rurwatt — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Minidoka
City of Heyburn
(No. ..... St.)
Registration District No. 18
Primary Registration District No. 2102
File No. 13925A
Registered No. 5
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Harold Rice

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH. June (Month) 11 (Day) 1910 (Year)

7. AGE 5 Yrs. 8 Mos. 1d ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John Henry Rice

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Jennie Alice Mills

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John H Rice by Kuwatt
(Address)

15. Filed Mch. 10 1916 V. P. Killen Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on Feb. 1916,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Drowning in Canal
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) V. P. Killen M. D.
19.... (Address) Rupert Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Heyburn Ida — DATE OF BURIAL 3/26 1916

20. UNDERTAKER Kuwatt # 150 — ADDRESS Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13926
Registered No.

1. PLACE OF DEATH.
Registration District No. 23
Primary Registration District No. 1017-2017
County of Lincoln
City of Jerome (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Catherine Jane Ulrich
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married
6. DATE OF BIRTH: June 22 1913 (Month) (Day) (Year)
7. AGE: 2 yrs. 6 mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Montana
10. NAME OF FATHER: Simon Peter Ulrich
11. BIRTHPLACE OF FATHER (State or Country): Texas
12. MAIDEN NAME OF MOTHER: Kate DeBarbeyrac
13. BIRTHPLACE OF MOTHER (State or Country): Texas
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs S. P. Ulrich
(Address)
15. Filed Jan 21 1915 E. D. Pipes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 19 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1916, to Jan 19 1916, that I last saw h[er] alive on Jan 19 1916, and that death occurred on the date stated above, at 1:30 P. M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(Duration) — yrs. — mos. 4 ds.
Contributory (Secondary) Cretinism
(Duration) 2 yrs. mos. ds.
(Signed) E. D. Pipes M. D.
Jan 21 1916 (Address) Jerome

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetery — DATE OF BURIAL: 1-21 1916
20. UNDERTAKER: D. A. Swenson — ADDRESS: Jerome

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13927

Registered No.

1. PLACE OF DEATH.
County of Lincoln
City of Jerome (No. St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 1017-2017

2. FULL NAME Ella Vera Farman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: March 24 (Month) (Day) 1883 (Year)

7. AGE: 32 yrs. 10 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: L. E. Edman

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Ana Nilson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. G. Farman
(Address) Jerome Ida

15. Filed Feb 2 1916 E. D. Tyler M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22 1915, to Jan 30 1916 that I last saw her alive on Jan 30 1916, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Miliary Tuberculosis of lungs & peritoneum

(Duration) yrs. 1 mos. 7 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Wm F. Schnerkall M. D.
Feb 4 1916 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetery
DATE OF BURIAL: 2-4 1916

20. UNDERTAKER: D. A. Berridge
ADDRESS: Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Ella Vera Fairman

now lying buried in Jerome Cemetery, in the City or Town of Jerome

County of Jerome State of Idaho, who died on the 1st day of February, 1916, Aged 32 years 10 months

7 days, the cause of death being Miliary tuberculosis of lungs & peritoneum and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

John F. Schmershall attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by Private
private or railway conveyance

to Wendell Cemetery in the City or Town of Wendell County of Gooding

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Jerome it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 9th day of April, A.D. 1958.

Permit issued to:
J. Forrest Weaver
Weaver Mortuary
Wendell, Idaho

W. F. Benson

by Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of _____ State of Idaho, this _____ day of _____, 19__.

_____

Health Officer

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13928

Registered No.

1. PLACE OF DEATH.
County of Lincoln
City of Jerome
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 1017-2017
(No. , St.)

2. FULL NAME Clarence Owen Gipson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 20 (Day) 1892 (Year) ~~1894~~

7. AGE: 24 yrs. 5 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Albert P. Gibson

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Edith Asher

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Clarence Gibson (wife)
(Address): Jerome Ida

15. Filed Feb 12 1916 C. D. Pfau Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1916, to Feb 12 1916, that I last saw him alive on Feb 11 1916, and that death occurred on the date stated above, at 3:54 M.

The CAUSE OF DEATH* was as follows:

Acute Gastritis &
Acute Myocarditis

(Duration) not known yrs. mos. ds.

Contributory (Secondary) Chronic Interstitial Nephritis

(Duration) not known yrs. mos. ds.

(Signed) C. D. Fleming M. D.

Feb 12 1916 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rockwood Ida
DATE OF BURIAL: 191

20. UNDERTAKER: A E Thompson
ADDRESS: Gooding

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13929

Registered No.

1. PLACE OF DEATH.
County of Lincoln
City of Jerome
If death occurs away from usual residence give facts called for under special information.

Registration District No. 23
Primary Registration District No. 1017-1027
(No. ....., ... St.)

2. FULL NAME Mary F Mitchell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: May (Month) 26 (Day) 1847 (Year)

7. AGE: 68 yrs. 7 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John B. Cain

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Mary Dudly

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nellie C. Folland
(Address) Jerome

15.
Filed Jan 23 1916
C. D. Pifer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1915, to Jan 23 1916 that I last saw her alive on Jan 15 1916, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Dropsy

(Duration) ..... yrs. 1 mos. ..... ds.

Contributory (Secondary) Brights Disease

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) C. D. Pifer M. D.

Jan 24 1916 (Address) Jerome

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place ..... In the
of death ..... yrs. ..... mos. ..... ds. State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Broomhall Stone Bridge
DATE OF BURIAL ..... 191...

20. UNDERTAKER: D. H. Henderson
ADDRESS: Jerome

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNE-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 2201
(No. ..... St.)

File No. V 13930
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Tryfan Hughes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH (X)
Jan (Month) xx (Day) 1915 (Year)

7. AGE
1 yrs. — mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Kellogg. Idaho.

10. NAME OF FATHER John R. Hughes

11. BIRTHPLACE OF FATHER
(State or Country) Wales

12. MAIDEN NAME OF MOTHER Mary Parry

13. BIRTHPLACE OF MOTHER
(State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John R. Hughes
(Address) Kellogg

15.
Filed Feb 8 1916. Geo S Leeber
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb. (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1915, to ~~Feb 10~~ and ~~Feb 11~~ Feb 12 1916
that I last saw him alive on ~~Feb 11~~ Feb 10 1916
and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Miliary Tuberculosis

(Duration) yrs. 5 mos. ds.
Contributory (Secondary) Not discovered
(Duration) yrs. mos. ds.

(Signed) Alex. D. McEachin M. D.
Feb 11 1916 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kellogg Idaho	Feb. 13 1916

20. UNDERTAKER	ADDRESS
M. C. Shankie	Kellogg Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics.

Registration District No. 123
Primary Registration District No. 2201
File No. 7895
Registered No.

1. PLACE OF DEATH.
County of Shoshone
City of 5 miles from Little North Fork. (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred C. Robertson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
(Month) (Day) 1895 (Year)

7. AGE
20 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER Fred C. Robertson

11. BIRTHPLACE OF FATHER (State or Country) Louisiana

12. MAIDEN NAME OF MOTHER Amelia DeLion

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Miller
(Address) Spokane Wash

15.
Filed 2/25 1916 Jno S Lasher
Local Registrar

SYMS - YORK CO., PTRS. & ENGRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
2 (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I ~~last~~ saw him ~~alive~~ on Feb 22 1916
and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Probably brain tumor
Died instantly I was
called immediately but
deceased was dead when
I arrived.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo. F. Kennett, M. D.
Feb 24 1916 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: Feb 25, 1916

20. UNDERTAKER: M. C. Thornhill ADDRESS: Kellogg, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Cataldo
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 2201
(No. ....., ... St.)

File No. 9 13932
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara Reinhofer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: February (Month) 15th (Day) 1881 (Year)

7. AGE: 35 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Paul A Schlagel.

11. BIRTHPLACE OF FATHER (State or Country): Hungaria

12. MAIDEN NAME OF MOTHER: Anna Middagh

13. BIRTHPLACE OF MOTHER (State or Country): Cannada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martin Arnhold.
(Address) Cataldo Idaho.

15. Filed Jan 11 1916 Geo. D Lester Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

M.D. Doctor
Suicide

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Bullet wound in head

..... (Duration) Suicide yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER: No undertaker | ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH.** Registration District No. 103
County of Shoshone Primary Registration District No. 2201
City of Kellogg (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.
File No. 10 13933
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** John W. Langford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M	White	Married (Write the word.)

6. **DATE OF BIRTH** ..... (Month) ..... (Day) 1858 (Year)

7. **AGE** 58 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) No info.

10. **NAME OF FATHER**

11. **BIRTHPLACE OF FATHER** (State or Country)

12. **MAIDEN NAME OF MOTHER**

13. **BIRTHPLACE OF MOTHER** (State or Country)

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) C. E. Lightner
(Address) Enaville Idaho

15. Filed 2/18 1916 Geo. L. Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH** Feb (Month) 11 (Day) 1916 (Year)

17. **I HEREBY CERTIFY,** That I attended deceased from Feb 10th 1916, to Feb 11 1916, that I last saw h*im* alive on Feb 11th 1916, and that death occurred on the date stated above, at 6:20 P.M.

The **CAUSE OF DEATH*** was as follows:
Lobar Pneumonia.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. 6 ds.

(Signed) H. C. Lindsay M. D.
2/12 1916 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. **PLACE OF BURIAL OR REMOVAL** Coeur d'Alene city | **DATE OF BURIAL** 2/15 1916

20. **UNDERTAKER** M. C. Thornhill | **ADDRESS** Kellogg, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 13938
Registered No. 7/15

1. PLACE OF DEATH.
County of Bannock
City of .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Henry Monshew

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. Aug (Month) 18 (Day) 1[illegible]5 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Pocatello Idaho.

10. NAME OF FATHER J. H. Monshew

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Libbie Williamson

13. BIRTHPLACE OF MOTHER (State or Country) North Carolina.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. H. Monshew
(Address) Pocatello Ida.

15. Filed Jan 30, 1916 W. F. Keely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan. (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1916, to Jan 29 1916, that I last saw h[illegible] alive on Jan 29 1916, and that death occured on the date stated above, at 7:00 A M.

The CAUSE OF DEATH* was as follows:
Bronchio pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Newton M. D.
Jan 29 1916 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho
DATE OF BURIAL: Jan 31 1916

20. UNDERTAKER: Larkin + Sons
ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13939
Registered No. 427

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bernice Christensen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
March 4 (Month) (Day) 1916 (Year)

7. AGE
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many. 14 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Pocatello Idaho.

10. NAME OF FATHER: A. E. Christensen

11. BIRTHPLACE OF FATHER
(State or Country) Denmark.

12. MAIDEN NAME OF MOTHER: Ada Barnes.

13. BIRTHPLACE OF MOTHER
(State or Country) Salt Lake Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. E. Christensen
(Address) 750 N. 12 Ave

15.
Filed 3-6 1916
O. B. Steele
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 5 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 1916, to March 5 1916, that I last saw her alive on March 5 1916, and that death occured on the date stated above, at 2a M.
The CAUSE OF DEATH* was as follows: Hemiplegia, (Stroke)

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. Hoskins M. D.
March 5 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida. DATE OF BURIAL: March 6 1917

20. UNDERTAKER: Larkin & Sons Co ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-16-13

Dr Howard

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. 327 S. 4th E. St.)

File No. 13940
Registered No. 430

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howard Thomas Krause

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH.: March (Month) 3 (Day) 1916 (Year)

7. AGE: ..... Yrs. ..... Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): Child

9. BIRTHPLACE (State or Country): Pocatello Idaho

10. NAME OF FATHER: Brigham Krause

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake City Utah

12. MAIDEN NAME OF MOTHER: Sarah Lula Day.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Brigham Krause
(Address) #327 S. 4th E. City

15. Filed Mar 14 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Men 3 1916, to Men 13 1916, that I last saw h alive on Mch 13 1916 and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Inanition ten days after Operation for Hernia of entire intestines
(Duration) — Yrs. — mos. 10 ds.
Contributory (Secondary) Hernia operation
Complete Hernia th umbilical cord
(Duration ..... yrs. ..... mos. 1/2 ds.

(Signed) W. T. Howard M. D.
3/14/16 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bountiful Utah — DATE OF BURIAL: Mar 16 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13941

Registered No. 429

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 656 West Bullett St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hilda Sarah Moore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. December 31 (Month) (Day) 1915 (Year)

7. AGE: Yrs. 0 Mos. 8 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Wm I Moore

11. BIRTHPLACE OF FATHER (State or Country): Alabama

12. MAIDEN NAME OF MOTHER: Lena Foulkes

13. BIRTHPLACE OF MOTHER (State or Country): Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W I Moore

(Address) 656 W. Bullett

15. Filed Mar 9 1916

O P Lee
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 8 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 1916, to March 7 1916, that I last saw her alive on Mar 7 1916, and that death occured on the date stated above, at about 5 A. M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary) Infantile ascending infection of bladder & Cloacal

(Duration yrs. mos. Few ds.

(Signed) J M Kay M. D.

19 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cemetery

DATE OF BURIAL: March 9 1916

20. UNDERTAKER: Schumacher & Hall.

ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2042

Registered No. 426

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 427 - North 4th St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Dolton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. March 2 (Month) (Day) 1916 (Year)

7. AGE: ....Yrs....Mos....ds.

IF LESS than 1 day how many 18 hrs. or 15 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jack F Dolton

11. BIRTHPLACE OF FATHER (State or Country): O

12. MAIDEN NAME OF MOTHER: Lenard

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack F. Dolton

(Address)

15. Filed Mar 3, 1916 O P Neal Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2 1916 (1:45 a.m.), to March 2 1916 (10: a.m.), that I last saw h[im] alive on March 2 1916 (10 a.m.), and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

—

Asphyxiation

F W Poole M D

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration ....yrs. ....mos. ....ds.

(Signed) Mrs. Annie Bird M. D.

19.... (Address) 905 - Bannock Ave Midwife

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: ....191....

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

6Y185 - YORK CO., PTRS. & BKBS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9 3944

Registered No. 435

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unsoka Jakii

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: Yellow.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write one word.): Single

6. DATE OF BIRTH. Not Known (Month) 1 (Day) (Year)

7. AGE: about 65 years. ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Cook

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Japan

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Larkin & Sons Co

(Address) Pocatello Ida

15. Filed 3-27-1916 O F Stone Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:

Gunshot wound L. Left chest

self inflicted

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs ..... mos. ..... ds.

(Signed) Francis A Poole M. D.

March 27 1916 (Address) Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello Idaho	March 29 1916
20. UNDERTAKER	ADDRESS
Larkin & Sons Co	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1945

Registered No. 434

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. ....., ... St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary O. Turner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Oct (Month) 28 (Day) 1843 (Year)

7. AGE: 72 Yrs. 4 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Nicklos Kelley

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. W. Newcomb

(Address) Pocatello Ida

15. Filed Mar 19 1916

O. J. Stevens
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1916, to March 16 1916, that I last saw h a alive on March 16 1916 and that death occured on the date stated above, at 2-10 P. M.

The CAUSE OF DEATH* was as follows!

Carcinoma

of Uterus Metastasis Ilium.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. J. Dacey M. D.

March 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho — DATE OF BURIAL: March 1916

20. UNDERTAKER: Larkin & Sons Co — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 13947
Registered No. 424

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mike Leon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 30 yrs. ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Section R. R.

9. BIRTHPLACE (State or Country): Greece

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Larkin & Sons Co
(Address) Pocatello Ida.

15. Filed 3 - 6 - 1916
O B Healy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 4 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3 - 2 1916, to 3 - 2 1916, that I last saw h[illegible] alive on 3 - 2 1916, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Shock following amputation of L leg, and internal injuries from being run over
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
3/11 1916 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida — DATE OF BURIAL: Mar. 6 1916
20. UNDERTAKER: Larkin & Sons Co — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13948

Registered No. 439

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No.....

Primary Registration District No.....

(No. 16 2nd Ave North St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter A Staley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. October (Month) 5 (Day) 1863 (Year)

7. AGE 53 Yrs. 4 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Florist

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER Levi Staley

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania — U.S.

12. MAIDEN NAME OF MOTHER Susanna Woodring

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs W. A. Staley

(Address).....

15. Filed Mar 1, 1916 — W B Steely, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1916, to July 27 1916, that I last saw h[illegible] alive on July 27 1916, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Cyanide Poisoning

Shock (3 hrs) Accidental

Cyanide (Duration) Yrs. mos. ds.

Contributory (Secondary) was taken by mistake for spray on flowers

(Duration) yrs. mos. ds.

(Signed) W B Steely M. D.

1920 19 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mountain View Cemetery — **DATE OF BURIAL** Mar 1, 1916

20. UNDERTAKER Schumacher & Hall. — **ADDRESS** Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13949

Registered No. 432

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No.

Primary Registration District No.

(No. 404 North 9th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fredrick Roberts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Exact date unknown: September (Month) (Day) 1870 (Year)

7. AGE: Near as known: 45 Yrs. 6 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Matt Roberts

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred V. Roberts

(Address) 404 N. 9th City

15. Filed Mar 17, 1916

O. B. Steed
Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1916, to Mch 15 1916, that I last saw him alive on Feb. 10 1916 and that death occured on the date stated above, at midnight

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

Mitral disease

(Duration) Few Yrs. mos. ds.

Contributory (Secondary) Mitral insufficiency

(Duration Several yrs. mos. ds.

(Signed) W J Hurst M. D.

3/16 1916 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Mch 15 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF D[illegible]

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13950

Registered No. 731

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha J. Tucker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write one word.): Widowed

6. DATE OF BIRTH: Jan (Month) 27 (Day) 1842 (Year)

7. AGE: 74 Yrs. 1 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: James Goodman

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Francis Fuller

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. O. Tucker
(Address) Mo. Pocatello. Roosevelt St.

15. Filed Mar. 19, 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1916, to March 16 1916, that I last saw her alive on March 16 1916, and that death occured on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — Yrs. — mos. 10 ds.

Contributory (Secondary): Senility

(Duration) few yrs. — mos. — ds.

(Signed) W. F. Arnold M. D.

3/18 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello Idaho	March 19 1916
20. UNDERTAKER	ADDRESS
Larkin & Sons	Pocatello

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13951
Registered No. 428

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No.....
Primary Registration District No.....
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis Inliker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)
7. AGE: About 60 years ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Janitor
9. BIRTHPLACE (State or Country): ## Hungaria
10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (State or Country): Not Known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Larkin + Sons Co
(Address) Pocatello Ida.
15. Filed Mar 10, 1916 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 7th (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mch 6 1916, to Mch 7 1916, that I last saw him alive on Mch 7 1916, and that death occured on the date stated above, at 8 a. M.
The CAUSE OF DEATH* was as follows:
(a) Ox.
Myocarditis
?
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Frances N Poole M. D.
Mch 9 1916 (Address) Pocatello.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho. DATE OF BURIAL: Mar. 11 1916
20. UNDERTAKER: Larkin + Sons Co. ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13952
Registered No. 425

1. PLACE OF DEATH.

Registration District No.....

Primary Registration District No.....

County of Bannonck

City of Pocatello (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John B Burke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.

Not Known (Month) (Day) 1 (Year)

7. AGE

About 50 years ....Yrs....Mos....ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Larkin + Sons Co

(Address) Pocatello

15.

Filed 3- 3- 1916

E. B. Steele
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 2 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1916, to March 2 1916, that I last saw h[illegible] alive on March 2 1916 and that death occured on the date stated above, at 6a. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) J. E. Bell M. D.

March 2 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello Idaho	March 16 1916
20. UNDERTAKER	ADDRESS
Larkin + Sons Co.	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13953

Registered No. 423

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No.....

Primary Registration District No.....

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Daniel Ask

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July 4th (Month) (Day) 1879 (Year)

7. AGE: 36 Yrs. 6 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Mine Digger

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Daniel L. Ask

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Olaf Ask

(Address) Pocatello Idaho

15. Filed Feb 25 1916

O P Steely
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 21 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Suffocation - buried beneath sand and gravel in mill - caused by cave in.

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Francis N Poole M. D.

Feb 21 1916 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Irwin Down

DATE OF BURIAL: Feb 29 1916

20. UNDERTAKER: Schumacher & Hall

ADDRESS: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13954
Registered No. 322

1. PLACE OF DEATH.
County of Bannock
City of Pocatello

Registration District No.....
Primary Registration District No.....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Kellow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 15 (Month) (Day) 1901 (Year)

7. AGE: 14 Yrs. 9 Mos. 20 ds.
IF LESS than 1 day how many .....hrs. or .....min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas Kellow

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jane Robbins

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Sam Kellow
(Address): Pocatello Idaho

15. Filed: Feb 22 1916 — O K Reed, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 20 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 17 1916, to Feb. 20 1916, that I last saw him alive on Feb. 17 1916, and that death occured on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows: Double Lobar Pneumnia

.....(Duration) — Yrs. mos. 14 ds.

Contributory (Secondary) .....

.....(Duration — yrs — mos. — ds.

(Signed) W. J. Howard M. D.
2/22 1916 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Feb 22 1916

20. UNDERTAKER: Schumacher & Hay — ADDRESS: City

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 913955

Registered No. 421

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No.

Primary Registration District No.

(No. 8. 2nd St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charlie Young

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Chinese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Exact date unknown (Month) (Day) 1872 (Year)

7. AGE: 44 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Waiter in
(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

9. BIRTHPLACE (State or Country) Nevada

10. NAME OF FATHER — Young

11. BIRTHPLACE OF FATHER (State or Country) China

12. MAIDEN NAME OF MOTHER — Ahkim

13. BIRTHPLACE OF MOTHER (State or Country) China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charlie Young
(Address) No. 333 So. 5th Ave.

15. Filed Feb 22 — 1916 F. J. Reed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 20th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
9
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
9
(Duration ... yrs. ... mos. ... ds.
(Signed) Francis A. Poole M. D.
Feb. 21 1916 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Feb 23 1916

20. UNDERTAKER: Schumacher Bros — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13956

Registered No. 420

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No.

Primary Registration District No.

(No. 538 N. Hayes St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Francis Kane

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. April (Month) 3 (Day) 1858 (Year)

7. AGE: 57 Yrs. 10 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Grocery Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 2 years

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Michael Kane

11. BIRTHPLACE OF FATHER (State or Country): County Kerry Ireland

12. MAIDEN NAME OF MOTHER: Anna Smith

13. BIRTHPLACE OF MOTHER (State or Country): County Cavin Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Schaffer

(Address) Pocatello Idaho

15. Filed 2-18-1916 O. F. Ewart Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13th, 1915, to Feb 16th, 1916, that I last saw him alive on Feb 16th, 1916, and that death occured on the date stated above, at 7:04 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism - paralysis

(Duration) 2 Yrs. 6 mos. ds.

Contributory (Secondary): Uterine Sclerosis

(Duration yrs. mos. ds.

(Signed) O. F. Ewart M. D.

Feb 18 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View

DATE OF BURIAL: Feb 19 1916

20. UNDERTAKER: Schumacher & Hay

ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 913957

Registered No. 478

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stella Amay Wilkinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.

May (Month) 21 (Day) 1 (Year)

7. AGE: 21 Yrs. 8 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Nebraska.

10. NAME OF FATHER: Andrew Johnson

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER: Anna

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E L Wilkinson

(Address) Pocatello Idaho

15. Filed Feby 7th 1916 O P Deeg Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1916, to Feb 6 1916, that I last saw h alive on Feb 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema.

(Duration) ..... Yrs. few hours mos. ..... ds.

Contributory (Secondary) Acute Nephritis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C S M. Newton M. D.

Feb 7 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt. View Cem. Pocatello Idaho — DATE OF BURIAL: Feb 9 1916

20. UNDERTAKER: Larkin & Sons Co. — ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13958

Registered No. 417

1. PLACE OF DEATH.

County of Bannock

City of Pocatello (No. ....., ... St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Phyliss Henderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.)
Male	White	Single

6. DATE OF BIRTH. Sept (Month) 2 (Day) 1913 (Year)

7. AGE 2 Yrs. 5 Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Pocatello Idaho

10. NAME OF FATHER Moadyn Henderson

11. BIRTHPLACE OF FATHER (State or Country) Logan Utah

12. MAIDEN NAME OF MOTHER Rena Butcher

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. Butcher

(Address) 841 No. 9th St.

15. Filed Feby 7th 1916 J. B. Green Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1915, to Feb 4 1916; that I last saw him alive on Jan 27 1916 and that death occured on the date stated above, at 0P M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis following acute Suppurative Rheumatism

(Duration) Yrs. 2 mos. 0 ds.

Contributory (Secondary) Acute Suppurative Rheumatism

(Duration yrs. 3/4 mos. ..... ds.

(Signed) J. McKay M. D.

19..... (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello.	Feb 7 1916
20. UNDERTAKER Larkin & Sons Co	ADDRESS Pocatello.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13959

Registered No. 216

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emil Hronek

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.

Not Known (Month) V (Day) 1 (Year)

7. AGE: About 38 years ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Larkin & Sons Co

(Address) Pocatello Ida

15. Filed 2-20- 1916

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 2, 1916
(Month) (Day) 2 (Year) 1916

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h.....alive on ..... 191...,

and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Carbolic Poisoning

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs.....mos.....ds.

(Signed) H. S. Baldwin M. D.

Feby 19 16 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho

DATE OF BURIAL: Feb. 19 1916

20. UNDERTAKER: Larkin & Sons Co.

ADDRESS: Pocatello.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13960

Registered No. 194

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H. Tranter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Jan (Month) 14 (Day) 1865 (Year)

7. AGE 51 Yrs. 1 Mos. 16 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Gents furnishings
(b) General nature of industry, business, or establishment in which employed (or employer)..... Salesman

9. BIRTHPLACE (State or Country) England.

10. NAME OF FATHER Joseph Tranter.

11. BIRTHPLACE OF FATHER (State or Country) England.

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Grace A. Tranter
(Address) Pocatello Idaho

15. Filed Jan 31, 1916 O B Green Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1915, to Jan 26 1916, that I last saw h[illegible] alive on Jan 26 1916, and that death occured on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:
Valvular disease of the heart

(Duration) ? Yrs. mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) Frances H. Poole M. D.
Jan 31 1916 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello Ida.	Jan 30, 1916
20. UNDERTAKER	ADDRESS
Larkin & Sons Co	Pocatello.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13961

Registered No. 413

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Shepherd Crosswhite

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: Yrs. Mos. ds.

IF LESS than 1 day how many 24 hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Idaho.

10. NAME OF FATHER: William O Crosswhite.

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Ethel Shepherd

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William O Crosswhite

(Address) 422-N Bannock

15. Filed Jan 31 1916 O B Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28th 1916, to Jan 28 1916, that I last saw h Live alive on Jan 28th 1916, and that death occured on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) Yrs. mos. ds.

Contributory (Secondary) 24 hours Labor

(Duration Yrs. mos. ds.

(Signed) W A Castle M. D.

Jan 31 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho

DATE OF BURIAL: Jan 31 1916

20. UNDERTAKER: Larkin & Sons Co

ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

OVUS - VITAL CO., PTDS. & STNR. 24058

Dr Poole

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1962

Registered No. 1/2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No 250 S 3rd St.)

2. FULL NAME Salvatore Giacomini

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Exact date unknown (Month) (Day) 1860 (Year)

7. AGE: 56 years Yrs. Mos. ds. (Near as known) IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: — Giacomini

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. Castellini
(Address) 250 S. 3rd ave.

15. Filed Jan 4 1916 O B Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 2nd 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Suffocation during an Epileptic Seizure
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Frances N Poole M. D.
Jan 7 1916 (Address) Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Jan 5 1916

20. UNDERTAKER: Schumacher & Hoy — ADDRESS: City

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13964

Registered No. 409

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. ....., ... St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unknown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Unknown

6. DATE OF BIRTH. about 5'-10" might "slightly tall" 165 lbs

(Month) (Day) (Year) 1

7. AGE about 40 years

40 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): not known

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Schumacher & Hall

(Address) Undertakers

15. Filed Feb 19 1916

O P Lee
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ? ? 191 ?

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Drowning —

Found in Portneuf River Feb. 16, 1916

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James A. Poole M. D.

Feb. 19 1916 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View Cem	Feb 19 1916
20. UNDERTAKER	**ADDRESS**
Schumacher & Hall.	Pocatello.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9 8 7 4

County of Nez Perce

Primary Registration District No. 97

File No. 13965

City of Lapwai

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorthea Moffitt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1901 (Year)

7. AGE: 15 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) School girl

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER R. Moffitt

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Jennie Cutler Wooster

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John N. Alley
(Address) Lapwai Ida

15. Filed April 17 1916 John N. Alley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 4 (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1915, to April 16 1916, that I last saw h[illegible] alive on April 16 1916, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

..... (Duration) 3 yrs. ..... mos. ..... ds.

Contributory (Secondary) Rheumatism

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John N. Alley M. D.

4-17-1916 (Address) Lapwai Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston | DATE OF BURIAL: 4-17 1916

20. UNDERTAKER: Nunn Bros | ADDRESS: Lapwai

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce
City of Lapwai
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2174
Primary Registration District No. 93
(No. ....., ... St.)

File No. 13966
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Cloudsteed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	Ind	Single

6. DATE OF BIRTH
4 (Month) 5 (Day) 1893 (Year)

7. AGE
23 yrs. ..... mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Dak

10. NAME OF FATHER Cloudsteed

11. BIRTHPLACE OF FATHER (State or Country) Dak

12. MAIDEN NAME OF MOTHER Little Bear

13. BIRTHPLACE OF MOTHER (State or Country) Dak

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John N. Alley
(Address) Lapwai

15.
Filed 4-18 1916 John N. Alley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
4 (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2 15 1916, to 4-18 1916 that I last saw h— alive on 4-17 1916 and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:
Consumption
(Duration) ..... yrs. 5 mos. ..... ds.
Contributory (Secondary) Tuberculosis
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) John N. Alley M. D.
4-18 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Dak. DATE OF BURIAL: not known 191..

20. UNDERTAKER Mann Bros. ADDRESS Lapwa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nezperce
City of Lap
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 97
Primary Registration District No. 2174
(No. ....., ... St.)

File No. 13967
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melvina Dolly Moffitt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Apr (Month) 15 (Day) 1906 (Year)

7. AGE: 9 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: R. J. Moffitt

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Virginia Cathrine Kreamer

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. J. Moffitt
(Address) .....

15. Filed 3-26 1916 John N. Alley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916, to Mar 26 1916, that I last saw h[illegible] alive on Mar 26 1916, and that death occurred on the date stated above, at 2 M.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
.....
.....
(Duration) 5 yrs. ..... mos. ..... ds.
Contributory (Secondary) Inflammatory Rheumatism
(Duration) [illegible] yrs. ..... mos. ..... ds.
(Signed) John N. Alley M. D.
3-26 1916 (Address) Lapwai

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lenore — DATE OF BURIAL: 3/27 1916

20. UNDERTAKER: Vann Bros — ADDRESS: Lapwai

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2051
File No. 13969
Registered No. 496

1. PLACE OF DEATH.
County of Ada
City of Boise (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Barbers

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH: Dec. 23. 1854
(Month) (Day) (Year)

7. AGE: 61 yrs. 2 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer & hotelkeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: William Barbers

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Pulke -

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Barbers
(Address) Ccthol, Ida.

15. Filed 4/10 1916 DD Swanson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 15. 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 10 1916, to March 15. 1916, that I last saw him alive on Feby 25. 1916, and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:
Valvular Disease of Heart
Chronic
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory Senile Cachexia.
(Secondary) Chronic 1 yr.
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Frank Veatch M. D.
3/16 1916 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Boise	3/17 1916
20. UNDERTAKER	ADDRESS
Reed	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2057
File No. 13970
Registered No. 495

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Reuben N. Warnock

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: August 11th (Month) (Day) 1856 (Year)

7. AGE: 59 yrs. 7 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: James C. Warnock

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Sarah Jane Hunt

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. M. Mathews
(Address) Coeur d'Alene, Idaho

15.
Filed 4/10 1916 D. D. Brunner
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 12th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st 1915, to March 12. 1916, that I last saw h[illegible] alive on March 11. 1916, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of face.

about 3 (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank D'Ewy M. D.
3/12 1916 (Address) Rathdrum Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs. 11 mos. 7 days. In the State about 10 yrs ..yrs. ..mos. ..days.
Where was disease contracted if not at place of death? near Coeur d'Alene, Ida.
Former or usual residence Coeur d'Alene, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene
DATE OF BURIAL: 3/13 1916

20. UNDERTAKER: Tabor & Son
ADDRESS: Rathdrum

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17

Primary Registration District No. 12

File No. 13971

Registered No. 1694

1. PLACE OF DEATH.

County of Kootenai

City of Parkdrum (No. ..., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dark Kane

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M	W	

6. DATE OF BIRTH

Dark Kane ..... 1 .....
(Month) (Day) (Year)

7. AGE

Dark Kane yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work Dark Kane

(b) General nature of industry business, or dstablishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sheriff.

(Address) Coeur d'Alene

15.

Filed 4/10 1916 D. D. Freeman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dark Kane ..... 191....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Found Bones 3½ Miles
South West Parkdrum Idaho
No Clue as to cause or Name

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Parkdrum	3/21 1916
20. UNDERTAKER	ADDRESS
Rick	P

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2051
File No. 13972
Registered No. 193

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Enoch P. Dyer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: April 19. 1836 (Month) (Day) (Year)

7. AGE: 79 yrs. 9 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Johnson Co, Mo.

10. NAME OF FATHER: Samuel Dyer

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Pamelia Ketchum

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George E. Dyer
(Address) Spokane, work.

15.
Filed 4/10 1916 D. D. Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 6th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 3. 1916, to February 6. 1916, that I last saw him alive on February 6 1916 and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis and Prostatitis.

(Duration) over 5 yrs. mos. ds.
Contributory (Secondary) Old Age
(Duration) yrs. mos. ds.

(Signed) Frank Weng, M. D.
2/7/1916 (Address) Rathdrum, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Idaho — DATE OF BURIAL: Feb 8 1916

20. UNDERTAKER: O. W. Stone — ADDRESS: Rathdrum

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Dr Howard

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 913973

Registered No. 240

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. Pocatello Gen. Hospital St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marie C Lundburg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 10 (Day) 1892 (Year)

7. AGE: 23 Yrs. 9 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): — —

9. BIRTHPLACE (State or Country): Rock Springs Wyoming

10. NAME OF FATHER: James Nelson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Informant: C P Lundburg

(Address) Burlington Idaho

ed Mar 5, 1916

Local Registrar

YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29 1916, to April 3 1916, that I last saw her alive on April 3 1916, and that death occured on the date stated above, at 2:30 p. M.

The CAUSE OF DEATH* was as follows:

Surgical Shock

Operation for Uterine Anemia

(Duration) — Yrs. — mos. One ds.

Contributory (Secondary) Abdominal Tumor

(Duration — yrs. 6 mos. — ds.

(Signed) W A Howard M. D.

4/4/16 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. 6 days In the State 3 yrs. — mos. — days

Where was disease contracted if not at place of death? Burlington Idaho

Former or usual residence Burlington Idaho

19. PLACE OF BURIAL OR REMOVAL: Falls Nebraska — DATE OF BURIAL: April 8 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

SHOULD BE WRITTEN IN UNFADING INK—THIS IS A PERMANENT RECORD. should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS DEATH in plain terms, so that it may be properly classified. Exact statement CUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13974
Registered No. 441

1. PLACE OF DEATH.

County of Bannock
City of Pocatello
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Fisher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Red.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dont know (Month) 1 (Day) (Year)

7. AGE: 45 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Cattleman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Fort Hall Reservation

10. NAME OF FATHER Dotsa Wanaka

11. BIRTHPLACE OF FATHER (State or Country) Dont know

12. MAIDEN NAME OF MOTHER Sofer Sack

13. BIRTHPLACE OF MOTHER (State or Country) Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. B. Stevens
(Address) Fort Hall Reservation

15. Filed Apr 10, 1916 — O. F. Stone, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 9 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:
Killed by train (accident)

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Francis A. Poole M. D.
Apr 9 1916 (Address) Corner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Fort Hall Reservation

19. PLACE OF BURIAL OR REMOVAL: Fort Hall Reservation — DATE OF BURIAL: April 10 1916

20. UNDERTAKER: Larkin & Sons Co — ADDRESS: Pocatello, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13976
Registered No. 195

1. PLACE OF DEATH.
County of Boise
City of Cascade
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. 15

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Jas Finch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1866 (Year)

7. AGE: 50 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G E Froggle
(Address) Cascade

15.
Filed Apr. 9 1916 Ruth McDonald Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1914., to 3—16 1916
that I last saw h. living alive on 3—2 1916,
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Consumption

..... (Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G E Froggle M. D.
..... 19..... (Address) Cascade

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 2 yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, If not at place of death? Boise
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Vanwyck Idaho
DATE OF BURIAL: 3-17 1916

20. UNDERTAKER: Frost
ADDRESS: .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13977
Registered No. 1

1. PLACE OF DEATH.
County of Boise
City of Cascade
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 15
(No. , St.)

2. FULL NAME Frank Humphreys

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 18[illegible] (Year)

7. AGE: 30 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Book Keeper
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: — Humphrey

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): G E Hoagle
(Address): Cascade

15.
Filed Apr 9 1916 Ruth McDonald Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1916., to 3-2 1916
that I last saw him alive on 2-28 1916,
and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Tuberculosis

..... (Duration) 2 yrs. ..... mos. ..... ds.
Contributory (Secondary): office work
..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) G E Hoagle M. D.
..... 19 ..... (Address) Cascade

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 6 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death? Ind
Former or usual residence: Indianapolis

19. PLACE OF BURIAL OR REMOVAL: Ind
DATE OF BURIAL: 191

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13978

Registered No. 16

1. PLACE OF DEATH.
County of Burke
City of Cascade
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 15
(No. , St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Thos Seymour

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Not Known (Month) (Day) 1 (Year)

7. AGE: about 40 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Prospector
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. Froggle
(Address)

15. Filed Apr 9 1916 Ruth McDonald Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: about 2 — 15 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: found frozen to death on trail date not Known

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. E. Froggle M. D.
19... (Address) Cascade Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was Disease contracted, If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kamiah Ida
DATE OF BURIAL: 2-27 1916

20. UNDERTAKER: None
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13979

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 11
County of Ada Primary Registration District No. 2003
City of Meridian (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Claude Gerald Ferrell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Aug. 16 (Month) (Day) 1914 (Year)

7. AGE: 1 yrs. 7 mos. ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kamiath, Idaho

10. NAME OF FATHER: James S. Ferrell

11. BIRTHPLACE OF FATHER (State or Country): Kan

12. MAIDEN NAME OF MOTHER: Maude M Lewis

13. BIRTHPLACE OF MOTHER (State or Country): Ariz —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. F. Ferrell
(Address) Meridian

15. Filed March 30 1916 C. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 29 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29 1916, to — 191..
that I last saw h— alive on — 191..,
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Drowning

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) 1/4 yrs. mos. ds.

(Signed) H. F. Ferrell M. D.
Mar 30 1916 (Address) H. F. Ferrell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Starr
DATE OF BURIAL: Mar 31 1916

20. UNDERTAKER: None
ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2003
(No. ..... St.)

File No. 13980
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Hogle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
F	W	Widowed (Write the word.)

6. DATE OF BIRTH: July (Month) 2 (Day) 1846 (Year)

7. AGE: 69 yrs. 5 mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Henry Ramsey

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John C Hickman
(Address) Meridian Ida

15. Filed Jan 27 1916 O. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1916 to Jan 26 1916
that I last saw her alive on Jan 26 1916
and that death occurred on the date stated above, at 1.30 P.M.
The CAUSE OF DEATH* was as follows: Acute Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.
Contributory (Secondary) La Grippe
(Duration) 6 yrs. ..... mos. ..... ds.
(Signed) J. F. Neal M. D.
1-27 1916. (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Jan 28 1916

20. UNDERTAKER: Frye & Summers | ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
File No. 13981
Registered No.

1. PLACE OF DEATH.
County of Ada.
City of Meridian (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary E. Chapman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow.

6. DATE OF BIRTH: Aug (Month) 8 (Day) 1845 (Year)

7. AGE: 70 yrs. 5 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: William Hinder.

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Mary Hitesheu

13. BIRTHPLACE OF MOTHER (State or Country): Maryland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest E. Chapman
(Address) Boise Ida.

15. Filed Feb 2 - 1916 C. L. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan Sept 30 1915, to Jan 30 - 1916, that I last saw her alive on Jan 30 1916, and that death occurred on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:
Uraemic Poisoning —

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Interstit Nephritis
(Duration) ..... yrs. 5 mos. ..... ds.

(Signed) C. L. Sutton M. D.
2-2- 1916 (Address) Meridian Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL: Feb-2- 1916

20. UNDERTAKER: Frey & Summers — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2003
(No. 1½ Miles N. E. of Meridian)

File No. 13982
Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur A Hawks.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept 21st (Month) (Day) 1866 (Year)

7. AGE: 49 yrs. 4 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Altona. Ills.

10. NAME OF FATHER: Austin Hawks

11. BIRTHPLACE OF FATHER (State or Country): Mass

12. MAIDEN NAME OF MOTHER: Lucinda Case

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A. A. Hawks.
(Address) Meridian, Idaho

15. Filed Feb 15 1916 L. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 14th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916 to Feb 14 1916, that I last saw h-- alive on Feb. 14 1916, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Mitral Lesion

(Duration) 2 yrs. mos. ds.
Contributory (Secondary) Chronic Nephritis
(Duration) 20 yrs. mos. ds.

(Signed) J. F. Neef M. D.
2-14-1916 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE. (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lincoln Neb
DATE OF BURIAL: 2/16 1916

20. UNDERTAKER: Schreiber & Sidenfaden
ADDRESS: Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
(No. .... St.)

File No. 13983
Registered No. .....

1. PLACE OF DEATH.
County of Ada
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin VanBuren Palmer.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
September 16th 1835
(Month) (Day) (Year)

7. AGE
80 Yrs. 5 Mos. ——— ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer & Stockraiser
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Machias, Charlotte, Maine

10. NAME OF FATHER: David Palmer.

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: ~~Eliz~~ Levina Berry

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William S. Palmer
(Address) Meridian Ida.

15.
Filed Feb 15 1916
C. L. Sutton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb 14th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1915, to Feb 14 1916, that I last saw h.... alive on Feb 14 1916, and that death occured on the date stated above, at 9.25 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Bright's Disease or Chronic Interstitial Nephritis with Arteriosclerosis.
(Duration) ——— Yrs. ——— mos. ——— ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Sutton M. D.
2/15 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Star Idaho — DATE OF BURIAL: 2/16 1916

20. UNDERTAKER: J. L. Ayers — ADDRESS: Star, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13984

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Meridian Idd

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11

Primary Registration District No. 2003

(No. ....., ... St.)

2. FULL NAME Roland L Gilbert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May 9 (Month) (Day) 1910 (Year)

7. AGE: Five Yrs. Ten Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Earl L. Gilbert

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Maude M. Hancock

13. BIRTHPLACE OF MOTHER (State or Country): North Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl L Gilbert

(Address) Meridian Idd

15. Filed March 27 1916 O L Dutton Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 27th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27 1916, to March 27 1916, that I last saw h alive on March 27 1916, and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Ate wild parsnips -
Died less than 1 hour from
1st symptoms - Convulsions
paralysis of respiratory muscles
(Duration) ..... mos. ..... ds.

Contributory (Secondary) Diabetes pupils -
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O L Dutton M. D.

19..... (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Ida

DATE OF BURIAL: 3/27 1916

20. UNDERTAKER: W S Waters

ADDRESS: Meridian Idd

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2003,
(No. ....., ... St.)

File No. 13985
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Joseph Humphrey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 22 (Day) 1913 (Year)

7. AGE: two yrs. Eight mos. seven ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, professsion, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ada County Idaho

10. NAME OF FATHER: Guy B. Humphrey

11. BIRTHPLACE OF FATHER (State or Country): Bloomfield Iowa
Guy B. Humphrey

12. MAIDEN NAME OF MOTHER: Ester E. Eaton

13. BIRTHPLACE OF MOTHER (State or Country): Reynolds Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Guy B Humphrey
(Address) RFD No 3 Boise Idaho

15. Filed March 30 1916 C. L. Dalton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11 1916, to Mar 29 1916
that I last saw him alive on March 27 1916,
and that death occurred on the date stated above, at 1030 P.M.
The CAUSE OF DEATH* was as follows: Pneumonia Bronchial

(Duration) ..... yrs. ..... mos. 21 ds.
Contributory (Secondary) La Grip
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. F. Neal M. D.
Mar 30 1916 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Idaho
DATE OF BURIAL: March 31 1916

20. UNDERTAKER: W. S. Mateer
ADDRESS: Meridian Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
(No. ....., ... St.)

File No. 13986
Registered No. .....

1. PLACE OF DEATH.
County of Ada
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W. Whittock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Feb (Month) 5 (Day) 1833 (Year)

7. AGE: 83 Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Halifax Co Va.

10. NAME OF FATHER Mitchel Whittock

11. BIRTHPLACE OF FATHER (State or Country) Va

12. MAIDEN NAME OF MOTHER Miss Hubbard

13. BIRTHPLACE OF MOTHER (State or Country) Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jno. W. Whittock
(Address) Meridian Ida

15. Filed April 7th 1916 C. L. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 7th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1916, to April 7th 1916, that I last saw him alive on April 6 1916, and that death occured on the date stated above, at 1.10 P.M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis &
Chronic Interstitial Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Sutton M. D.
19..... (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL: 4-8-1916

20. UNDERTAKER: W. D. Mulen — ADDRESS: Meridian

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

6YMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

Primary Registration District No. 2003

File No. 13987

Registered No. .....

County of Ada

City of Meridian (No. 6 Miles W. W. Meridian St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Edward Gosso

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 26 (Month) (Day) 1910 (Year)

7. AGE: 5 Yrs. 11 Mos. 10 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Edward L. Gosso

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Addie Slutter

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. L. Gosso

(Address) Boise

15. Filed April 6th 1916

C. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1st 1916, to April 5th 1916, that I last saw him alive on April 4th 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic bronchitis
And Cerebro Spinal
Meningitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Dutton M. D.

19..... (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 4/9 1916

20. UNDERTAKER: Schreiber & Redington | ADDRESS: Boise

Information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WITH UNFADING INK—THIS IS A PERMANENT RECORD.

...ED FOR BINDING

EVANS - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13988

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 11

Primary Registration District No. 2013

County of Ada

City of Meridian (No. 1 Mile South St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Marcellus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Feb. (Month) ..... (Day) 1856 (Year)

7. AGE: 59 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: William H Marcellus

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Malinda Pool

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) I P Marcellus

(Address) Barry Idaho

15. Filed Feb 16 1916 C. L. Dellow Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 15 1916 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15 1916, to Feb 15 1916, that I last saw him alive on Feb 15 1916 and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy Cerebral

(Duration) ..... Yrs. ..... mos. 2 hours ds.

Contributory (Secondary) Paralysis

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) H. F. Kent M. D.

2-16 1916 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery | DATE OF BURIAL: 2/17 1916

20. UNDERTAKER: Schreiber & Sidwell (Boise) | ADDRESS

BYRNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13989

Registered No. .....

Registration District No. 76

Primary Registration District No. 2153

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Custer

City of Macky

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helene Holman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 9 (Day) 1916 (Year)

7. AGE: .....Yrs. .....Mos. 28 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Custer Co Idaho

10. NAME OF FATHER: Ben Holman

11. BIRTHPLACE OF FATHER (State or Country): Pleasant Grove Utah

12. MAIDEN NAME OF MOTHER: Maggie Shawry

13. BIRTHPLACE OF MOTHER (State or Country): Pleasant Grove Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ben Holman

(Address) Macky Idaho

15.

Filed Apr 19 1916 — R. Marie Rivers, Local Registrar

SYMS - YORK CO., PTRS. & BOOS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1916, to April 17 1916, that I last saw h.r. alive on April 17 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal Toxemia

.....(Duration) .....Yrs. .....mos. 8 ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) R E Mason M. D.

1916 (Address) Macky Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Grove U.

DATE OF BURIAL: .....191.....

20. UNDERTAKER: W. E. Beethan

ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Benewah
City of Fernell

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 13990
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Butler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March 9 1916 (X)
(Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Fernell Idaho

10. NAME OF FATHER: Harry B Butler

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Pauline Bynton Cochran

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry B Butler
(Address) [illegible]

15.
Filed 3-14 1916 H. L. M.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 15 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9 1916, to March 14 1916 that I last saw him alive on March 14 1916 and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Enlarged Thymus

..... (Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) —
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm Leete M. D.
March 15 1916 (Address) St Joe Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Maries Idaho
DATE OF BURIAL: Mar 16 1916

20. UNDERTAKER: H L McKeeby
ADDRESS: St Maries

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock
City of Lenore

Registration District No. 92
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 13992
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary L Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 23 (Day) 1881 (Year)

7. AGE: 35 Yrs. ..... Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Peter Larsoon

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Sorsert

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lucius M Thompson
(Address) Lenore

15.
Filed 3/29 1916 H. L. M. Local Registrar

SVMS - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1914, to Mar 28 1916, that I last saw her alive on Mar 28 1916, and that death occured on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:
Valvular disease of heart
Cardiac Insufficiency

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) Hard work

(Duration 5 yrs. mos. ds.

(Signed) J. Kinsolving M. D.
19 (Address) St Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lenore — DATE OF BURIAL: 3-31 1916

20. UNDERTAKER: H L Mulcahy — ADDRESS: St Maries

Or Hetman

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2049
(No. ..... , ... St.)
File No. 13993
Registered No. .....

1. PLACE OF DEATH.
County of Bonneville
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella Maria Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Dec (Month) 24 (Day) 1887 (Year)

7. AGE
28 Yrs. 2 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
a) Trade, profession or particular kind of work: Housework wife
b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Sigfrid

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Axel M Peterson
(Address) St Maries

15. Filed 3-13 1916 H L H Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 2 1916, to Mar 11 1916, that I last saw her alive on Mar 11 1916, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
General Peritonitis

(Duration) Yrs. mos. 6 ds.
Contributory (Secondary) Abortion
(Duration) yrs. mos. 5 ds.
(Signed) Owen D Plass M. D.
Mar 11 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 3/13 1916

20. UNDERTAKER: H. L. Mulcahy — ADDRESS: St Maries

MS - YORK CO., PTRS. & BOBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Benewah
City of Saint Maries (No. ....., ... St.)
Registration District No. 32
Primary Registration District No. 2049
File No. 13996
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edson Tifft

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	White	married

6. DATE OF BIRTH.
September (Month) 3rd (Day) 1863 (Year)

7. AGE
53 Yrs. 5 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... contractor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Michigan

10. NAME OF FATHER
John Tifft

11. BIRTHPLACE OF FATHER
(State or Country) Michigan

12. MAIDEN NAME OF MOTHER
Mary Pettitt

13. BIRTHPLACE OF MOTHER
(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Margaret Tifft
(Address) St Maries Idaho

15.
Filed Mar 1 1916
H L Mulcahy
Local Registrar

BYNS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
2 (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 17th 1916, to Feb 27th 1916, that I last saw him alive on Feb 27 1916, and that death occured on the date stated above, at 2.50 A. M.

The CAUSE OF DEATH* was as follows:
Pleuro Pneumonia
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. 10 ds.
(Signed) Owen D Platt M. D.
Mar 1 1916. (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Maries Idaho	3/1 1916

20. UNDERTAKER	ADDRESS
H L Mulcahy	St Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32

Primary Registration District No. 2049

File No. 13997

Registered No. .....

1. PLACE OF DEATH.

County of Bonneville

City of St Maries

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Mc Ellen Robinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 6 (Day) 1850 (Year)

7. AGE 65 Yrs. 2 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: A. Lee

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Susan Gibson

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. A. Robinson

(Address) St Maries Idaho.

15. Filed Feb 26 1916 H. L. Mulcahy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1916, to Feb 26 1916, that I last saw her alive on Feb. 26 1916, and that death occured on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Dilatation Incompetency of the heart,

Organic disease of heart,

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Hemiplegia 9 Days

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. Hunsaker M. D.

2-26 1916 (Address) St Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries Idaho — DATE OF BURIAL: 2-27 1916

20. UNDERTAKER: H. L. Mulcahy — ADDRESS: St Maries

BYNS - YORK CO., PTRS. & BORS. 24654

mail to H. L. Mulcahy

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 32

Primary Registration District No. 2049

County of Bonneville

City of Ferrell

(No. ..... St.)

File No. .....

Registered No. 13998

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Lillie Rorpaugh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH.

December (Month) 1 (Day) 1871 (Year)

7. AGE

44 Yrs. 2 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE

(State or Country) California

10. NAME OF FATHER: Charles C Tautphaus

11. BIRTHPLACE OF FATHER

(State or Country) New York

12. MAIDEN NAME OF MOTHER: Sarah J. Kane

13. BIRTHPLACE OF MOTHER

(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs K. L. Johnston

(Address) Idaho Falls Idaho

15.

Filed 2-15 1916 H. L. Mulcahy
Local Registrar

BYRNS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1916, to Feb 14 1916, that I last saw her alive on Feb 14 1916, and that death occured on the date stated above, at 5:20 P M.

The CAUSE OF DEATH* was as follows:

La Grippe & Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H M Leete M. D.

Feb 15 1916 (Address) Ft Jn Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida

DATE OF BURIAL ..... 191...

20. UNDERTAKER: H. L. Mulcahy

ADDRESS H. Main

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13999

Registered No. .....

1. PLACE OF DEATH.

County of Benewah

City of or Firmwood.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Wayne Ross

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 27 (Day) 1913 (Year)

7. AGE: ..... Yrs. two Mos. Eight ds. 13

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mount Hope Wash.

10. NAME OF FATHER Emmet Merle Ross

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Alma Bartelt

13. BIRTHPLACE OF MOTHER (State or Country) Mount Hope, Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emmet Merle Ross

(Address) Firmwood, Idaho

15.

Filed Mar 24 1916

H L Mulcahy
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1916 to ..... 191..., that I last saw h alive on Feb. 14 1916, and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Accidental
Drowning

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs.....mos.....ds.

(Signed) Geo W Cain M. D.

.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Idaho — DATE OF BURIAL: Feb 17 1916

20. UNDERTAKER: H L Mulcahy — ADDRESS: St Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 32

Primary Registration District No. 2049

File No. 14000

County of Shoshone

City of Roland

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Luke Pijy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Don't know

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 40 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cement Worker on

(b) General nature of industry, business, or establishment in which employed (or employer): Rail R.R.

9. BIRTHPLACE (State or Country): Don't Know

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred G. Parkins

(Address) Herrick, Idaho

2-14 1916 H. L. Mullaly Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2- (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Accidently Shot by step on Rail, Engine and Instantly Killed

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred G. Parkins M. D.

2-12 1916 (Address) Herrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....,mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mann — DATE OF BURIAL: 2-15 1916

20. UNDERTAKER: H. L. Mullaly — ADDRESS: Mann

... PTRS. & BDRS. 24854

V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

County of Bonneville

City of N. Maine

(No. ....., ... St.)

Registration District No. 32

Primary Registration District No. 2049

File No. 14001

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John McGee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	Single

6. DATE OF BIRTH. Don't Know (Month) 1 (Day) (Year)

7. AGE 71 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) In Poor House for years.

9. BIRTHPLACE (State or Country) Don't Know

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N. S. McCauley

(Address) N. Maine

15. Filed 2-26 1916 N. S. McCauley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1915, to Feb 25 1916, that I last saw h— alive on Feb 24 1916, and that death occured on the date stated above, at 6.a.m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary) Debility + heart disease.

(Duration 6 yrs. mos. ds.

(Signed) C. H. Linsenmire M. D.

2-26 1916 (Address) Ft Maginnis, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL N. Maine — DATE OF BURIAL 2-26 1916

20. UNDERTAKER N. S. McCauley — ADDRESS N. Maine.

YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Benewah

City of St. Maries

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14002

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo C Vordell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 64 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Concrete Work on

(b) General nature of industry, business, or establishment in which employed (or employer): Mil R.R.

9. BIRTHPLACE (State or Country): Pa

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Vordell

(Address) 1827 Stafford Ave Spokane

15. Filed Feb. 2 1916 W. L. Mulcahy Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1916, to Feb 2 1916, that I last saw h alive on Feb 2 1916, and that death occured on the date stated above, at 3-20 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

2 (Signed) D Vordell M. D.

2 1916 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL ..... 191...

20. UNDERTAKER: W L Mulcahy — ADDRESS Spokane

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 97
Primary Registration District No. 2119
File No. 14003
Registered No. 9

1. PLACE OF DEATH.
County of Franklin
City of Preston
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lyerd Hallingworth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. [illegible] (Month) 24 (Day) 1910 (Year)

7. AGE ..... Yrs. 6 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Preston Idaho Franklin Co

10. NAME OF FATHER Marion Hallingsworth

11. BIRTHPLACE OF FATHER (State or Country) Preston Idaho

12. MAIDEN NAME OF MOTHER Nora Bosworth

13. BIRTHPLACE OF MOTHER (State or Country) Preston Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. James Bosworth
(Address) Preston Idaho

15. Filed 4/10 1916 D A Rulon Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 15th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11th day 1916, to March 15th 1916, that I last saw him alive on March 15 1916, and that death occured on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows: Pneumonia - Broncho

.....(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Dr R T Caulfield M. D.
.....19..... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL [illegible] Idaho — DATE OF BURIAL Jan 17 1916

20. UNDERTAKER H. A. Skidmore — ADDRESS
Per A. A. Monson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (b) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*," "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 14004
Registered No. 11

1. PLACE OF DEATH.
County of Franklin
City of Preston
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fanny Cartwright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 20 (Day) 1847 (Year)

7. AGE: 68 Yrs. 10 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pelsall Staffordshire Eng.

10. NAME OF FATHER: Thomas Hooker

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Bott

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry Cartwright
(Address)

15. Filed 4/10 1916 Drake Rulle Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28, 1916, to March 31 1916, that I last saw h[illegible] alive on March 31, 1916, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis — cerebral

(Duration) 1 Yrs. 0 mos. 0 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

4/3 1916 (Signed) Curtis Bland M. D.
(Address) Preston, Idah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: April 5 1916

20. UNDERTAKER: W. A. Skidmore
ADDRESS: Preston

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
(No. ..... St.)

File No. 14005
Registered No. 8

1. PLACE OF DEATH.
County of Franklin
City of Weston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jerusha Dees

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Feb. (Month) 2 (Day) 1860 (Year)

7. AGE: 56 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Brigham city Bottelder Co. Utah.

10. NAME OF FATHER: Leander Clifford

11. BIRTHPLACE OF FATHER (State or Country): Contuca.

12. MAIDEN NAME OF MOTHER: Ada Mathis

13. BIRTHPLACE OF MOTHER (State or Country): Wales.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ira M. Dees
(Address) Weston Idaho

15.
Filed 4/7 1916 D. A. Kellar
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar. (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 17 [redacted], to Mar 5 1916, that I last saw her alive on Feb 21st 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute Dilatation of Heart
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R. W. Dennis M. D.
3/9 1916 (Address) Franklin Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days
In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weston Idaho
DATE OF BURIAL: 3/8 1916

20. UNDERTAKER: H. A. Skidmore
ADDRESS: Preston
Per A. A. Anderson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS - YORK CO., PTRS. & BKBS. 24058

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2048
File No. 16
Registered No. 14007

1. PLACE OF DEATH.
County of Bonneck
City of Soda Springs
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leo Leroy Mennyes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. (X) Nov (Month) 17 (Day) 1915 (Year)

7. AGE: ..... Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Soda Springs

10. NAME OF FATHER: Melvin Mennyes

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Grace Byrnyton

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Myself (Dr Kanely)
(Address) Soda Springs

15. Filed April 10, 1916 Ellis Kanely
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23, 1916, to March 28 1916, that I last saw h[illegible] alive on March 23 1916, and that death occured on the date stated above, at 1P M.

The CAUSE OF DEATH* was as follows:
Convulsions
2 days
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
2 days
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Ellis Kanely M. D.
4/9 19 16 (Address) Soda Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Soda Springs
DATE OF BURIAL: March 29 1916

20. UNDERTAKER: Ed Whitmire
ADDRESS: Soda Spgs

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2 14010

Registered No. 1

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH.

County of Bannock

City of Lava Hot Springs Idaho (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Miss Kate Giard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: French

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March (Month) 7th (Day) 1858 (Year)

7. AGE: 58 Yrs. ..... Mos. ..... ds. 9

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper for
(b) General nature of industry, business, or establishment in which employed (or employer): Bro Henry Giard

9. BIRTHPLACE (State or Country): St. Joe. Mo

10. NAME OF FATHER: John Giard

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Mary Du Train

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. F. Giard
(Address) McCammon - Idaho

15. Filed April 19 1916 Eric Kinney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 16th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1915, to March 16 1916, that I last saw h.er alive on March 16th 1916 and that death occured on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:
Cancer of the Right Breach

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) none

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Powell M. D.

March 19 17 (Address) Lava Hot Springs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Hiawatha Kansas

19. PLACE OF BURIAL OR REMOVAL: McCammon Idaho — DATE OF BURIAL: March 18 1916

20. UNDERTAKER: D. E. Johnson. Licence # 129 — ADDRESS: McCammon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Downey
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2046
(No. ....., ... St.)

File No. 20
Registered No. 14011
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Redington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH
Oct. ~~23~~ 5 (Month) 23 (Day) 1835 (Year)

7. AGE
80 yrs. 5 mos. 10 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Essex, England

10. NAME OF FATHER Joseph Redington

11. BIRTHPLACE OF FATHER (State or Country) dont know

12. MAIDEN NAME OF MOTHER Elizabeth Littlechild

13. BIRTHPLACE OF MOTHER (State or Country) Essex England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Redington
(Address) Oxford Idaho

15.
Filed April 4 1916 Ellen Kaney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
4 (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1916 to Apr 2 1916
that I last saw h[illegible] alive on Apr 2 1916
and that death occurred on the date stated above, at 6 p. M.

The CAUSE OF DEATH* was as follows:
Acute myocarditis
.....
.....
(Duration) ..... yrs. 3 mos. ..... ds.
Contributory (Secondary) Senility
(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
Apr 4 1916 (Address) Downey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Downey, Idaho | DATE OF BURIAL April 4 1916

20. UNDERTAKER B P Downey | ADDRESS Downey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14012

Registered No. 16

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 4

County of Gem Primary Registration District No. 1008

City of Payette (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert L Maxfield

Mar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write this word.): Married

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1853 (Year)

7. AGE: 62 yrs. 6 mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer (Retired)
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Robert Maxfield

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Sarah Pettyfish

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. T. Bishop
(Address) Payette

15. Filed March 24 1916 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1914, to March 21 1916, that I last saw him alive on March 21 1916 and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) About yrs. 10 mos. ..... ds.

Contributory (Secondary) Paretic Dementia

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) O. H. Avery M. D.

3/24/1916 (Address) Payette, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: Mar 25 1916

20. UNDERTAKER: J. N. Adair — ADDRESS: Payette Ida

SYMS - YORK CO., PTRS. & BDRS. 19780

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 5168
File No. 14013
Registered No. 50

1. PLACE OF DEATH.
County of Clearwater
City of Lenore
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Elizabeth Fouchek

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 19 (Day) 1915 (Year)

7. AGE: Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Jos Fouchek

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Maude Thomas

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jos Fouchek
(Address) Lenore Idaho

15. Filed Apr 1 1916
J. M. Stacy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 29 1916, to Mch 31 1916, that I last saw h. alive on March 29 1916, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 2 Yrs. mos. 4 ds.

Contributory (Secondary) Whooping Cough

(Duration yrs. mos. 10 ds.

(Signed) John E. Hoyt M. D.

4-1-16 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cavendish
DATE OF BURIAL: 4-2 1916

20. UNDERTAKER: none
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

Burial permits issued 7-11-57

TO: K. H. Malcom
Brower-Wann Memorial
Lewiston, Idaho

July 6, 1957
Date

Department of Public Health
Boise, Idaho

I hereby give authorization for the disinterment of: four babies

NAME OF DECEASED 1) Anton Xaver Fruchtl 2) Anna Elizabeth Fruchtl 3) Wilbert August Fruchtl 4) Wilma Adelaide Fruchtl

DATE OF DEATH 1) Jan. 7, 1915 2) Mar. 31, 1916 3) Dec. 2, 1916 4) Nov. 11, 1917

CAUSE OF DEATH 1) Lived only few hours 2) Pneumonia 3) Stillborn 4) Complications at birth

ATTENDING PHYSICIAN Dr. Horsewell - Kendrick, Ida. - Dr. Hoyt - Orofino, Ida.

BURIED IN Teakean Cemetery CEMETERY

TO BE REMOVED TO Normal Hill - Lewiston, Idaho CEMETERY

RELATIONSHIP TO PERSON REQUESTING PERMIT Father

NAME OF LICENSED EMBALMER Unknown

REASON FOR DISINTERMENT To move to family plot.

(Witness) Helen Tode, Clarkston, Wn.

~~Very truly yours~~,

(Witness) Marie Glasson, Lewiston, Ida.

His
Joe A. Fruchtl-Mark (X)
Signature of relative or person requesting permit.

12th Street Nursing Home, Clarkston, Wash.
Address

- * * * * * * * * * * * * * * -

State of Idaho)
County of Nez Perce) ss

On this 6th day of July, 1957, before me John William King a Notary Public in and for the within county and state personally appeared Joe A. Fruchtl known to me (or proved by the oath of _____) to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same.

In Witness whereof I have hereunto set my hand and affixed my official seal this the day and year first above written.

John William King
Notary Public, residing at Lewiston, Idaho
My commission expires December, 1960

(Seal)

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14014

Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 96

Primary Registration District No. 2168

(No. Northern Idaho Sanitarium St.)

County of Clearwater

City of Orofino

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Pangborn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. (Month) — (Day) — (Year) 1849

7. AGE: 67 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): — —

12. MAIDEN NAME OF MOTHER: — —

13. BIRTHPLACE OF MOTHER (State or Country): — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Stevens

(Address) Orofino. Idaho.

15. Filed Apr 10 1916

J. M. Faith
Local Registrar

SYMS - YORK CO., PTRS. & SOLS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1906, to Mar 29 1916, that I last saw h[illegible] alive on Mar 25 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(Duration) — Yrs. — mos. 2 ds.

Contributory (Secondary): Insanity

(Duration) 16 yrs. 3 mos. 16 ds.

(Signed) John Stevens M. D.

Mar 29 1916 (Address) Orofino. Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 16 yrs. 3 mos. 16 days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death? Shoshone County

Former or usual residence: Shoshone County

19. PLACE OF BURIAL OR REMOVAL: Sanitarium Cemetery — DATE OF BURIAL: Mar 31 1916

20. UNDERTAKER: Peter M. Johnson — ADDRESS: Orofino Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1405
Registered No. 13

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 2168
City of Orofino (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Lloyd Wheeler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov 16 (Month) (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Clearwater Co Idaho

10. NAME OF FATHER: Leon Wheeler

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Ethel Smith

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Leon Wheeler
(Address): Orofino

15. Filed 12/12 1916 J. M. Fairey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 28 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1916, to Nov 28 1916, that I last saw him alive on Nov 27 1916 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Hemorrhage from umbilicus followed by hemorrhage from bowels
(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. C. Moran M. D.
12/12 1916 (Address) Orofino

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida. DATE OF BURIAL: Nov. 30 1916

20. UNDERTAKER: none ADDRESS: -

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: *(a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Z #15 File date

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14016
Registered No. 14

1. PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 40
Primary Registration District No. 2168
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josephine Leiteb

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (If widowed): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1886 (Year)

7. AGE: 30 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Leiteb

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Mary Leiteb

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Leiteb Jr. Brother
(Address): Orofino

15.
Filed 4/10 1916 J. M. Dailey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 4 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 1915 to Mar 4th 1916
that I last saw her alive on ..... 191...
and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Puerperal Hemorrhage
Shock
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. M. Worswell M. D.
..... 19..... (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arrasha Ida
DATE OF BURIAL: Mar 6 1916

20. UNDERTAKER: W. E. Stoddard
ADDRESS: Gifford

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90 -
Primary Registration District No. 2168
File No. 14017
Registered No. 15

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Little

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 8 (Day) 1857 (Year)

7. AGE: 58 yrs. 3 mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: J. W. Little

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: M. Lovell

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Price Riddle
(Address) 4. E Collins

15.
Filed Apr 12 1916 J. M. Davey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1916, to March 7 1916, that I last saw h... alive on March 7 1916 and that death occurred on the date stated above, at 11:10 A.M.

The CAUSE OF DEATH* was as follows:
Toxic Condition due to Gangrene of Legs - Myocardial Insufficiency
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Paraplegia - arterial sclerosis with further obstruction of femoral artery
(Duration) ..... yrs. ..... mos. 45 ds.

(Signed) Earle M. Worswell M. D.
3/8 1916 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida
DATE OF BURIAL: Mar 9 1916

20. UNDERTAKER: W. E. Stoddard
ADDRESS: Gifford

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14018
Registered No. 16

1. PLACE OF DEATH.
County of Clearwater
City of Ahsahka
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168

2. FULL NAME Mary Pederson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Widowed~~ Married

6. DATE OF BIRTH: May 1 1851 (Month) (Day) (Year)

7. AGE: 64 yrs. 6 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Insin

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Theo. Pederson
(Address) Ahsahka Ida

15.
Filed 3/11 1916
J. M. Bailey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 11 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1915, to March 11 1916 that I last saw her alive on Aug 29 1915 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) -

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) J. M. Bailey M. D.
3/12 1916 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Headquarters, Ida — DATE OF BURIAL: 3/12 1916

20. UNDERTAKER: W. E. Bloedel — ADDRESS: Orofino Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Ahsahka
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 2168
(No. ____, ____ St.)

File No. 14020
Registered No. 18
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edwin Samuels

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Indian	Single

6. DATE OF BIRTH
Aug (Month) 19 (Day) 1908 (Year)

7. AGE
7 yrs. 5 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Student
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Louis Samuels

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Thomas

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis Samuels
(Address) Ahsahka, Ida

15.
Filed 3/26 1916 J M Tandy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 20 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 13 1916, to Mar 25 1916, that I last saw him alive on Mar 25 1916 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia, Bronchial

(Duration) ____ yrs. ____ mos. 12 ds.

Contributory (Secondary) Tuberculosis

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. M. Tandy M. D.
3/25 1916 (Address) Orofino, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Ahsahka, Ida — DATE OF BURIAL: 3/27 1916

20. UNDERTAKER: O. E. Haddad — ADDRESS: Kendrick Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 14021
Registered No. 19
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Adell Clarke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Married (or Widowed)

6. DATE OF BIRTH ~~March 31~~ June 6 1856
(Month) (Day) (Year)

7. AGE 59 yrs. 9 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Michigan

10. NAME OF FATHER Nelson Tupper

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Sarena Lockwood

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Swanson Snyder
(Address) Orofino Ida

15.
Filed 4/10 1916 J M Tandy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 31 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1916 to March 20 1916
that I last saw h~~e~~r alive on March 23 1916
and that death occurred on the date stated above, at 8:35 P M.

The CAUSE OF DEATH* was as follows:
Arterial Sclerosis & tuberculosis

(Duration) 10 yrs. ..... mos. ..... ds.
Contributory (Secondary) General bowel & Malnutrition
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eula Wharton M. D.
3/31 1916 (Address) Orofino

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Fair Ida. DATE OF BURIAL: 4/3 1916

20. UNDERTAKER: A.A. Shaw ADDRESS: Orofino Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2056
Primary Registration District No. 29
File No. 1423
Registered No. 173

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant of E. A. Dahlgren

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Mar. (Month) 25 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 15 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Coeur D'Alene

10. NAME OF FATHER E. A. Dahlgren

11. BIRTHPLACE OF FATHER (State or Country) Minnesota

12. MAIDEN NAME OF MOTHER Signa Skoglund

13. BIRTHPLACE OF MOTHER (State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Evelin E. Dahlgren
(Address) 511 C.D.A. Ave C.D.A.

15. Filed 3-31 1916 Mayd Blalock Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Still born

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Wynn M. D.

3/27 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Mch. 27 1916

20. UNDERTAKER: T. E. Rudd — ADDRESS: C.D.A.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BNRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2050
Primary Registration District No. 29
(No. ....., ... St.)

File No. 11024
Registered No. 72

1. PLACE OF DEATH.
County of Kootenai
City of Town of Athol

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Willard Harper

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: ..... Yrs. 11 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: Frank Harper

11. BIRTHPLACE OF FATHER (State or Country): Wash

12. MAIDEN NAME OF MOTHER: Vera Crawford

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. E. A. Harper
(Address) .....

15. Filed 3-31 1916 Mora Morland Local Registrar

SYMS - YORK CO., PTRS. & SDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-19- 1916, to 3-19- 1916, that I last saw h[illegible] alive on 3-19- 1916 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Spinal Meningitis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Alexander Baron M. D.
3-23 1916. (Address) 611 Garden Ave Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sunset Cem — DATE OF BURIAL: Mar 27 1916

20. UNDERTAKER: S J Breen — ADDRESS: Athol

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai — Registration District No. 2050 — File No. 11025

City of Post Falls — Primary Registration District No. 29 — Registered No. 11

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Holm

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Feb. (Month) 2 (Day) 1895 (Year)

7. AGE 21 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Post Falls.

10. NAME OF FATHER Tom. Holm.

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Caroline Holm.

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward Norman Holm
(Address) Post Falls Ida.

15. Filed 3-31 1916 Max Ehland Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191..., that I last saw h— alive on ——— 191..., and that death occured on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:
Acute dilatation of heart. following
Toxi cardatis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Alexander Cameron Coroner M. D.
3-16 1916 (Address) 611 Garden Ave Coda

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Post Falls	Mar. 17 1916
20. UNDERTAKER	**ADDRESS**
J. E. Hedal	Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2030
Primary Registration District No. 29
File No. 4026
Registered No. 170

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah C. McConnell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 29th 1866 (Month) (Day) (Year)

7. AGE: 49 Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: James William McConnell

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sarah Dyer

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. W. McConnell
(Address) Coeur d'Alene

15. Filed 3-31 1916 Mora Morland Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 20 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1916, to Mar 20 1916, that I last saw h alive on Mar. 18 1916 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach and intestines

(Duration) Dec Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) J. O. Wyn M. D.

3/20 1916 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: March 21 1916

20. UNDERTAKER: T. C. Nordale — ADDRESS: C. D. A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14027

Registered No. 14

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No. 205

Primary Registration District No. 29

(No. ..... , ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary M. Russell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widowed

6. DATE OF BIRTH. August 11 1853
(Month) (Day) (Year)

7. AGE: 63 Yrs. 7 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Sam Pine

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George Russell
(Address) 836 3rd Coeur d'Alene, Ida.

15. Filed March 31 1916 — Mor d Hoblaud, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 21 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9 1915, to Mch 21 1916, that I last saw h[er] alive on Mch 18 1916 and that death occured on the date stated above, at 8 30 A. M.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Byers M. D.

3/22, 1916 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Mch 23 1916

20. UNDERTAKER: T. E. Hudson — ADDRESS: C. D. A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOK. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14028
Registered No. 14

1. PLACE OF DEATH (Registration District No. 2050)
County of Kootenai (Primary Registration District No. 29)
City of Coeur D'Alene (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kenneth A. Frederic

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb. 27 (Month) (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Coeur D'Alene

10. NAME OF FATHER: John Frederic

11. BIRTHPLACE OF FATHER (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Ayott

13. BIRTHPLACE OF MOTHER (State or Country): N. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Frederic
(Address) 306 Garden Ave Coeur d'Alene Ida

15. Filed 3-5 1916 M. S. Ward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar. 5 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 27 1916, to Mar 5 1916, that I last saw h[im] alive on Mar 5 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Dwyer M. D.

Mar 6 1916 (Address) Coeur d Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Mar. 6 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

V.S. No. 1

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County of Kootenia

City or Town of Ford Idaho

Registration Dist. No. 69

WASHINGTON STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 14029

File No. 6

Registered No. 18

(No. ..... St.; ..... Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information"]

Full Name Edward M. Iverson

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): married

6 DATE OF BIRTH: Aug (Month) 30 (Day), 1869 (Year)

7 AGE: 46 yrs. 6 mos. 19 ds. If LESS than 1 day, 20 hrs. or ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Lacross Wisconsin

PARENTS

10 NAME OF FATHER: Martin Iverson

11 BIRTHPLACE OF FATHER (State or country): Christaina Norway

12 MAIDEN NAME OF MOTHER: Annie Iverson

13 BIRTHPLACE OF MOTHER (State or country): Christaina Norway

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John M. Chappell

(Address) Ford Idaho

15 Filed Mch 20, 1916 W. R. Odell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 11 (Day), 1916 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March, 1916, to Mar 10 1916, that I last saw h.. alive on Mch 28, 1916, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH * was as follows:

Leukocythemia

(Duration) 1 yrs. 2 mos. ..... ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Chappell, M. D.

Mar 17 1916. (Address) Valley Ford Wn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Mica Creek — DATE OF BURIAL: March 14, 1916.

20 UNDERTAKER: John M. Chappell — ADDRESS: Ford, Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2050
Primary Registration District No. 20
File No. 614030
Registered No. 17

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Bertha Nickelsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): widowed
6. DATE OF BIRTH: May (Month) 19 (Day) 1849 (Year)
7. AGE: 66 yrs. 9 mos. 20 ds.
IF LESS than 1 day how many .....*hrs. or* .....*mins.?*
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Norway
10. NAME OF FATHER: Falvdn
11. BIRTHPLACE OF FATHER (State or Country): Norway
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (State or Country): Norway
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs O Anderson
(Address) 417 S. 12- Coeur D'Alene
15.
Filed 3-11 1916 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 10 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 6 1916, to Mar. 6 1916, that I last saw h Er alive on March 6 1916, and that death occurred on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:
Apoplexy.
(Duration) — yrs. — mos. 1 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John Ellwood M. D.
Mar. 11 1916 (Address) Coeur d Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Mar. 13 1916
20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No. 2050

Primary Registration District No. 29

(No. ....., ... St.)

File No. 14631

Registered No. 76

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elma Marie Arnell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.)

6. DATE OF BIRTH. Oct. (Month) 8 (Day) 1907 (Year)

7. AGE: 8 Yrs. 4 Mos. 28 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Hayden Lake

10. NAME OF FATHER Mark Arnell

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Cade Mary Hennighoffer

13. BIRTHPLACE OF MOTHER (State or Country) Spokane Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M R Arnell

(Address) Post Falls Ida

15. Filed 3-5-1916 W A Rowland Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. 5 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1915, to Mar 5 1916, that I last saw her alive on Mar. 5 1916 and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Myers M. D.

3/6 1916 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverview

DATE OF BURIAL: Mch. 7 1916

20. UNDERTAKER: J C Kinkaid

ADDRESS: C d A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2050
Primary Registration District No. 99
File No. 014032
Registered No. 15

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Glen L Brockman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1908 (Year)

7. AGE: 8 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: Lee Brockman

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Ruby Regina

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L P Brockman
(Address) Coeur d'Alene Idaho

15. Filed 3-9 1916 W E Stebbins Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 9 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1916, to March 9 1916, that I last saw him alive on March 9 1916, and that death occured on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis

(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pernicious Albuminuria with Uremic Coma
(Duration 3 yrs. ..... mos. ..... ds.

(Signed) W H Haldeman M. D.
March 9 1916 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Rockford Wash
DATE OF BURIAL: March 11 1916

20. UNDERTAKER: S Green
ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Clearwater (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 106
Primary Registration District No. 2184

File No. 14034
Registered No. 33
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Gunter Taylor

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 2nd (Day) 1885 (Year)

7. AGE: 31 yrs. 1 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: John Gunter

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Annie Hunter

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert C Taylor
(Address) Clearwater

15. Filed April 15 1916 J M. Vanbeekum Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1916, to Mar 19 1916, that I last saw h Sr alive on Mar 19 1916, and that death occurred on the date stated above, at 9P M.

The CAUSE OF DEATH* was as follows:
Puerperal fever
(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) H W Wentworth M. D.
March 19 16 (Address) Stites Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clearwater | DATE OF BURIAL: May 21 1916

20. UNDERTAKER | ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 75
Primary Registration District No. 2152
File No. 2
Registered No. 14035

1. PLACE OF DEATH.

County of Lewis
City of South W of Culdesac (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Jane Denham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. July (Month) 17 (Day) 1846 (Year)

7. AGE: 69 Yrs. 8 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Caretaker
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Samuel Sanders

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Miss L Morgan

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E L Denham
(Address) Slickpoo Idaho

15. Filed March 23 1916 Lloyd F Smith Local Registrar

SYMS - YORK CO., PTRS. & BKBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1916, to March 21 1916, that I last saw h.. alive on March 16 1916 and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows: Diaphragmatic Rheumatism

(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Mitral Regurgitation
(Duration) prior yrs. ..... mos. ..... ds.
(Signed) John N Calley M. D.
3-22-1916 (Address) Lapwai

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Culdesac — DATE OF BURIAL: Mar 23 1916

20. UNDERTAKER: H L Radabaugh — ADDRESS: Culdesac

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2128
File No. 14036
Registered No.

1. PLACE OF DEATH.
County of Lewis
City of Kamiah (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: About 63 yrs. ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kamiah

10. NAME OF FATHER: Dont know

11. BIRTHPLACE OF FATHER (State or Country): Dont know

12. MAIDEN NAME OF MOTHER: Sarah Cook

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Rosa Johnson
(Address) Kamiah

15. Filed 3/13 191 6 W. F. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15 1916, to date 191, that I last saw her alive on 3/12 1916, and that death occurred on the date stated above, at 6 00 P. M.

The CAUSE OF DEATH* was as follows:
Nephritis

(Duration) ..... yrs. 6 mos. ..... ds.
Contributory (Secondary) Metritus & Cystitis
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) C. O. Bryan M. D.
3/13 1916 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind Count No. 2 | DATE OF BURIAL: 3/15 1916

20. UNDERTAKER: C. J. Johnson | ADDRESS: Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14037

Registered No. 12

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 2/12

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Nixon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.

— (Month) — (Day) 1832 (Year)

7. AGE 83 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) N. Carolina

10. NAME OF FATHER Jos Nixon

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Miss Lacy

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irwin Goldsmith

(Address) Weiser R. D.

15. Filed 3-18 1916 W. P. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1916, to March 16 1916, that I last saw h im alive on March 15 1916, and that death occured on the date stated above, at 12 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Mitral Insufficiency

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James A Young M. D.

March 17 1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mann Creek — DATE OF BURIAL 3/17 1916

20. UNDERTAKER Northcutt & McCown — ADDRESS Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

6YM8 - YORK CO., PTRS. & BOBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
(No. .... St.)

File No. 14038
Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Washington
City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laurence Jackson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male.	White.	Single

6. DATE OF BIRTH. May 07 1913
(Month) (Day) (Year)

7. AGE 2 Yrs. 10 Mos. [redacted] ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9. BIRTHPLACE (State or Country) Indian Valley Ida

10. NAME OF FATHER Chas. L. Jackson

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Edith Andrews

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles L Jackson
(Address) Indian Valley. Idaho

15.
Filed 3-10 1916 W. R. Hamilton Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-8 1916, to 3-9 1916, that I last saw h— alive on 3-9-16 1916, and that death occured on the date stated above, at 11:9 M.

The CAUSE OF DEATH* was as follows:
Pneumonia Abdominal
.....
.....
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. 4 ..... ds.
(Signed) Canace C. Grant M. D.
3/9 1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Indian Valley	Mar 11 1916

20. UNDERTAKER	ADDRESS
Northam & McCann	Weiser Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Lanark
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 53
Primary Registration District No. 2132
(No. ..... St.)

File No. 14039
Registered No. 39
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kennett Burk

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH
March 13 (Month) 1 (Day) 1916 (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lanark Ida

10. NAME OF FATHER Peter Burk

11. BIRTHPLACE OF FATHER (State or Country) Russia

12. MAIDEN NAME OF MOTHER Marie Egle Burk

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred N. Passey
(Address) Lanark Ida

15.
Filed March 4 1916 J. Fulton Local Registrar
4-10-1916

SYMS - YORK CO., PTRS. & BDRS. 19760

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 14 191 , to Mar 14 1916
that I last saw h.. alive on Mar 14 1916,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Lot Cubley M. D.
3-15 1916 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lanark Ida — DATE OF BURIAL: Mar 15 1916

20. UNDERTAKER: Bishop Passey — ADDRESS: Lanark Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 53

Primary Registration District No. 2132

(No. .... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14040

Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bear Lake

City of Paris

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): X

6. DATE OF BIRTH. April (Month) 6 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 6 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Baby

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Paris

10. NAME OF FATHER James F Painter

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Leone Caldwell

13. BIRTHPLACE OF MOTHER (State or Country) Bear Lake Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James F Painter

(Address) Paris Ida.

15. Filed 4-10-1916 J. J. Fulton Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-6-1916, to 4-6-1916, that I last saw her alive on 4-6-1916, and that death occured on the date stated above, at 8:00 A.M.

The CAUSE OF DEATH* was as follows:

Premature (7 mo)

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) J. J. Fulton M. D.

April 6 1916 (Address) Paris

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris — DATE OF BURIAL: 4-7-1916

20. UNDERTAKER: Mrs. Caldwell — ADDRESS: City

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14041

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of Chester

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 95

Primary Registration District No. 2177

(No. .... St.)

2. FULL NAME Rosa E. Hill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Baby

6. DATE OF BIRTH. V (Month) VO (Day) 191a (Year)

7. AGE: ..... Yrs. 1 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Chester Ida

10. NAME OF FATHER John Hill

11. BIRTHPLACE OF FATHER (State or Country) Fremont Co Ida

12. MAIDEN NAME OF MOTHER Laura Williams

13. BIRTHPLACE OF MOTHER (State or Country) Fremont Co Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Lilly Williams
(Address) Chester Idaho

15. Filed Apr 10 1916 W. D. Wright Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/10 1916, to 3/22/ 1916, that I last saw her alive on 3/22/ 1916, and that death occured on the date stated above, at 11 P. M,

The CAUSE OF DEATH* was as follows:

Pertussis

..... (Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary) none

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John R Gray M. D.

3/24/1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Chester Idaho — DATE OF BURIAL: 3/25/ 1916

20. UNDERTAKER — ADDRESS

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14043
Registered No. 25

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Providence Hospital St.)

Registration District No. 70
Primary Registration District No. 1911

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eugene Cooper Sheets

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec. 18 1915 (Month) (Day) (Year)

7. AGE: 0 yrs. 1 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J M Sheets

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Harriett Bailey

13. BIRTHPLACE OF MOTHER (State or Country): Mont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J M Sheets
(Address): Wallace King St

15.
Filed FEB 14 1916 191
F Leo Tunby
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb 14th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18th 1916., to Feb 14th 1916
that I last saw him alive on Feb 10th 1916
and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Lack of vitality on Premature birth

(Duration) yrs. 1 mos. 27 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C B Stone M. D.
Feb 14th 1916 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Providence Hosp. 0 yrs. 1 mos. 27 ds. In the State 0 yrs. 1 mos. 27 ds.
Where was disease contracted, if not at place of death?
Former or usual residence: Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: 2-15 1916

20. UNDERTAKER: Breen & Wortley
ADDRESS: Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 70

Primary Registration District No. 1011

(No. Cotton Grove St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14044

Registered No. 32

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Jensen

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. X (Month) (Day) 1 (Year)

7. AGE: Yrs. 9 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wallace Ida

10. NAME OF FATHER: C. V. Jensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Emma Sorensen

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. V. Jensen

(Address) [redacted]

15. Filed March 22 1916 — F. Leo Trude, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 21st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch. 18th 1916, to Mch 21st 1916, that I last saw her alive on Mch 19th 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Contusion of Cerebellum

(Duration) Yrs. 2 mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. S. Olson M. D.

Mch 22 1916. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Wallace Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Mar 22 1916

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-15

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1014
(No. Providence Hospital)

File No. 14045
Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Wallace

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Freeman Miller

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Nov (Month) 26 (Day) 1914 (Year)

7. AGE
1 Yrs. 2 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Vancouver B.C.

10. NAME OF FATHER
Robert Freman Miller

11. BIRTHPLACE OF FATHER
(State or Country) Prince Edward Island

12. MAIDEN NAME OF MOTHER
Annie Mary Gustafson

13. BIRTHPLACE OF MOTHER
(State or Country) Mann. Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R F Miller
(Address) Cataldo Ida

15.
Filed Feb 24 1916
F Leo Tinsley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1916, to Feby 24 1916, that I last saw him alive on Feby 23 1916, and that death occured on the date stated above, at 6 00 P.M.

The CAUSE OF DEATH* was as follows:
Cerebro Spinal Menin
Pneumococcus M-
Bacillaris
(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D W Morgan M. D.
2/24/16 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Cataldo Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace
DATE OF BURIAL: Feb 24 1916

20. UNDERTAKER: Ward Hud Co
ADDRESS: Wallace Ida

DYER - YORK CO., PTRS. & BKBS. 24058

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEA
Bureau of Vital St

1. PLACE OF DEATH.

County of Fremont — Registration District No. 19 — File No. 1404[illegible]

City of St Anthony — Primary Registration District No. 2177 — Registered No.

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Greene

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 12 (Day) 1913 (Year)

7. AGE: ....Yrs. 3 Mos. 7 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): St Anthony Ida

10. NAME OF FATHER: Heber Greene

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Emma Hollingsworth

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Norman Ward

(Address) St anthony Ida

15. Filed Mar 20 1916 — [illegible] — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 9 1916, to Mar 19 1916, that I last saw her alive on Mar 19 1916, and that death occured on the date stated above, at 11:25 P.M.

The CAUSE OF DEATH* was as follows:

Hydrocephalis

.....(Duration) ....Yrs. 3 mos.....ds.

Contributory (Secondary)

.....(Duration....yrs.....mos.....ds.

(Signed) J Myrtle D M. D.

Mar 20 1916 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Anthony Cemetery — DATE OF BURIAL: Mar 21 1916

20. UNDERTAKER: none — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHY should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Fremont
City of Egin
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. ....., ... St.)

File No. 14047
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Levi Richard White

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 7 (Day) 1915 (Year)

7. AGE: ..... yrs. 8 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Egin Idaho

10. NAME OF FATHER: Joseph J White

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Eliza May Chandler

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J F White
(Address) .....

15. Filed Apr 10 1916 W D Arnold Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1916, to Mar 28 1916, that I last saw h— alive on Mar 27 1916, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W D Arnold M. D.

Apr 7 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Alma — DATE OF BURIAL: Mar 30 1916

20. UNDERTAKER — ADDRESS —

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14051
Registered No.

1. PLACE OF DEATH.
County of Custer
City of ——— (No. ———, ——— St.)

Registration District No. 14
Primary Registration District No. 205-7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jerry H. Mahoney

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Unknown (Month) 1 (Day) (Year)
7. AGE: about 40 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Telegraph operator
(b) General nature of industry business or establishment in which employed (or employer): Miner
9. BIRTHPLACE (State or Country): Unknown
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P H Ranches
(Address) Stanley Idaho
15.
Filed Mch 7 1916 O. N. Ranches
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March — 7 — 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Killed by snow slide on Sunbeam Mountain accident.
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence. Middle fork of Salmon River

19. PLACE OF BURIAL OR REMOVAL: Greyhound Mine
DATE OF BURIAL: Mch 13 1916
20. UNDERTAKER: Friend
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14052
Registered No. 1.

1. PLACE OF DEATH.
County of Custer
City of Challis
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maud M Chivers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: wh.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married

6. DATE OF BIRTH: Nov (Month) 20 (Day) 1885 (Year)
1916 − 31 = 85

7. AGE: 31 yrs. 3 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Thomas Jozl

11. BIRTHPLACE OF FATHER (State or Country): Australia

12. MAIDEN NAME OF MOTHER: Margit Hoffaron

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mable Adamson
(Address) Challis Ida

15.
Filed Mar 15 1916 H C Lamell Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) 9 yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. L. Kirkby M. D.
19.... (Address) Challis, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Challis Ida
DATE OF BURIAL: 3/16 − 1916

20. UNDERTAKER: Friends
ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Boise

Primary Registration District No. 2019

File No. 14053

City of Idaho City

(No. ....., ... St.)

Registered No. 35

If death occurs away from usual residence, give facts called for under special information

2. FULL NAME Wilhelmina Betsy Leton.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH

Unknown, 1
(Month) (Day) (Year)

7. AGE

About 70 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Prussia

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15.

Filed April 10 1916 May Fit Deputy.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 16 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from never attended 191, to 191,

that I last saw h..... alive on 191,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

unknown. Had not been well old and quiter, found dead in bed.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. G. Fit. M. D.

Apr 10 1916. (Address) Placerville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho City	Mar. 17 1916

20. UNDERTAKER	ADDRESS
Had none.	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14054

Registered No. 32

1. PLACE OF DEATH.
County of Idaho
City of Clearwater (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 106
Primary Registration District No. 2184

2. FULL NAME William Harrison Lytle

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: November 25th 1850 (Month) (Day) (Year)

7. AGE: 65 yrs. 3 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: William Lytle

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Eleanor Lake Fultz

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mabel Grace Lytle
(Address) Stites Idaho

15.
Filed March 11 1916 Jno. Verbarg
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 5th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...
that I last saw him alive on February 6th 1916
and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Autotoxication - Chronic

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteria Sclerosis
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Wentworth M. D.
March 1916 (Address) Stites Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Clearwater | DATE OF BURIAL: March 6 1916

20. UNDERTAKER: Family | ADDRESS: Stites Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone — Registration District No. 123

City of Kellogg — Primary Registration District No. 2201

(No. ....., ... St.)

File No. 14055

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph N. Washburn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1836 (Year)

7. AGE: 80 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: no info.

11. BIRTHPLACE OF FATHER (State or Country): no info.

12. MAIDEN NAME OF MOTHER: no info.

13. BIRTHPLACE OF MOTHER (State or Country): no info.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas. N. Washburn
(Address) Kellogg Idaho

15. Filed 3/10 1916 Geo. S. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Apoplexy —
Felt sick about 1 hour - dead before physician arrived.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) Alex. McCracken M. D.
Mar 10 1916 (Address) Kellogg Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elgin Illinois — DATE OF BURIAL: Mch 11, 1916

20. UNDERTAKER: M. C. Crawford — ADDRESS: Kellogg Ida

DYMO - YORK CO., PTRS. & BORS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.
Registered No. 14056

1. PLACE OF DEATH.
County of Kootenai
City of 3 mi N.E. Dudley (No. , St.)

Registration District No.
Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Arnhard (Sr)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March (Month) 18 (Day) 1845 (Year)

7. AGE: 68 yrs. ✓ mos. ✓ ds. IF LESS than 1 day how many ✓ hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria Hungary

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martin Arnhard Jr
(Address) Cabinet, Ida.

15. Filed Mar 18 1916 Geo. D. Forbes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Visited him one time ~~Saw him~~ this ~~last saw him~~ alive ~~last seen~~ 191 and that death occurred on the date stated above, at 7 1/2 M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) ✓ yrs. ✓ mos. ✓ ds.

Contributory (Secondary)
(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) C. E. Worthington M. D.
3/18 1916 (Address) Rosedale Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 68 yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Old Mission Cemetary DATE OF BURIAL: 3/20. 1916

20. UNDERTAKER: No Undertaker ADDRESS: Cabinet, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14057

Registered No. [illegible]

1. PLACE OF DEATH.

County of Shoshone

City of Kellogg

(No. ....., ... St.)

Registration District No. 123

Primary Registration District No. 2201

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Grace Bellinger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb. (Month) 23 (Day) 1876 (Year)

7. AGE: 39 Yrs. 6 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Wm McLellan

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Katie Wagner

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bellinger

(Address) Kellogg

15. Filed 3/28 1916 Geo D Leshure Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 1916, to Nov 13 1916, that I last saw her alive on Nov 18 1916, and that death occured on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary) La grippe.

(Duration) 2 yrs. 1 mos. ds.

(Signed) M. McLinedoon M. D.

3/27 1916 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: Mch 16 1916

20. UNDERTAKER: M C Rankin — ADDRESS: Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone

City of Wardner

Registration District No. 123

Primary Registration District No. 2201

(No. ....., ... St.)

File No. 14

Registered No. 14058

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Duncan McIntyre

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Mar (Month) 30 (Day) 1861 (Year)

7. AGE: 55 Yrs. ..... Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: John McIntyre

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Kathryn McCowan

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jessie McIntyre

(Address) Wardner, Idaho

15. Filed 4/6/ 1916 Geo J Lesser Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29 1916, to Apr 4th 1916, that I last saw him alive on Apr 3rd 1916, and that death occured on the date stated above, at 2.25a M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Lindsay M. D.

4/5 1916 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane Wash	Apr 6 1916
20. UNDERTAKER	**ADDRESS**
W. C. Thornhill	Kellogg, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BNRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Fremont
City of St Anthony
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. ..... St.)

File No. 14059
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura Parker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mar 30 (Month) (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Fremont Co

10. NAME OF FATHER: Lionel Parker

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Vawdrey

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emeline Brower
(Address) .....

15.
Filed ..... 191...
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr 2 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 31 1916, to Apr 2 1916, that I last saw h[illegible] alive on Apr 2 1916, and that death occurred on the date stated above, at 1 2 M.

The CAUSE OF DEATH* was as follows:

Infantile convulsions

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parker
DATE OF BURIAL: Apr 3 1916

20. UNDERTAKER: None
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99

Primary Registration District No. 2172

File No. 14060

Registered No. .....

1. PLACE OF DEATH.

County of Fremont

City of County

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith Bond

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 15 (Day) 1895 (Year)

7. AGE: 20 Yrs. 8 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Steven a Bond

11. BIRTHPLACE OF FATHER (State or Country): Provo Utah

12. MAIDEN NAME OF MOTHER: Emily a Siddoway

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A J Siddoway

(Address) Teton

15. Filed Apr 10 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/25/16 to 2/25/16, that I last saw her alive on 2/25/16 and that death occured on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) none

(Duration ..... yrs. none mos. ..... ds.

(Signed) J R Gray M. D.

2/26 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Teton

DATE OF BURIAL: 2/26/16

20. UNDERTAKER: none

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2137
(No. ..... St.)

File No. .....
Registered No. 14061

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Fremont
City of St Anthony
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary C Hutchinson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 3 (Day) 1880 (Year)

7. AGE: 36 Yrs. 7 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Richmond Utah

10. NAME OF FATHER: Tom Hill

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hannah Thomsen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Hutchinson
(Address) St Anthony Ida

15. Filed Apr 10 1916 — W D Clegg, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/15 1916, to 3/18 1916, that I last saw h[illegible] alive on 3/15 1916, and that death occured on the date stated above, at 12 — M.

The CAUSE OF DEATH* was as follows:
Pulmonary Embolism
(Duration) — Yrs. — mos. 8 ds.
Contributory (Secondary) Abortion
(Duration) — yrs. — mos. 8 ds.
(Signed) John P Rigby M. D.
19 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191

20. UNDERTAKER | ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Fremont
City of Parker
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. ....., ... St.)

File No. 14062
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo A Smith Crapo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Jan (Month) 23 (Day) 1 (Year)

7. AGE: 40 yrs. 1 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Geo Crapo

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Emily Burnham

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W Ward
(Address) .....

15. Filed Mar 10 1916 W Ward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 10 1916, to Mar 19 1916, that I last saw him alive on Mar 19 1916, and that death occurred on the date stated above, at 29 M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W Ward M. D.
19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Parker	Mar 21 1916

20. UNDERTAKER	ADDRESS
None	—

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 1976O

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14063

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of St Anthony (Ward) No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 2177

2. FULL NAME Elizabeth Ann Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Nov (Month) 14 (Day) 1853 (Year)

7. AGE: 63 Yrs. 3 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Salt Lake Utah

10. NAME OF FATHER: James Udy

11. BIRTHPLACE OF FATHER (State or Country): Cornwell England

12. MAIDEN NAME OF MOTHER: Isabell Ann Cowley

13. BIRTHPLACE OF MOTHER (State or Country): Isle of Man

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T E Smith Jr

(Address) St Anthony Idaho

15. Filed Apr 10 1916 W S Everett Local Registrar

MEDICAL CERTIFICATE OF DEATH *

16. DATE OF DEATH: Mar (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1916, to Mar 1916, that I last saw her alive on Jan 20 1916, and that death occured on the date stated above, at 3.15 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. freed dy

Contributory (Secondary) Cerebritis

(Duration 7 yrs. ..... mos. ..... ds.

(Signed) J Moorfield M. D.

Mar 11 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Milford Cemetery — DATE OF BURIAL: Mar 12 1916

20. UNDERTAKER: None — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24654

Form V. S. No. 51 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14064

Registered No. 29

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 104
(No. Providence Hosp St.)

2. FULL NAME Michall J Maher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Sept (Month) 5 (Day) 1856 (Year)
7. AGE: 59 yrs. 6 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: merchant
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: John Maher
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Catherine Ryan
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J Phiffer
(Address) Wallace
15. Filed MAR 13 1916 191 F. L. Coventry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 10 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1916, to May 10 1916
that I last saw h[illegible] alive on May 10 1916
and that death occurred on the date stated above, at 8:45 P.M.
The CAUSE OF DEATH* was as follows:
Coronary of the Lungs & adjacent glands
(Duration) yrs 6 mos. ds.
Contributory (Secondary): None
(Duration) yrs. mos. ds.
(Signed) Dr Mowry M.D.
5/11 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place Providence Hosp in the City of Wallace
of death ..... yrs ..... mos ..... ds. State ..... 32 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? Burke Idaho
Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash
DATE OF BURIAL: 3-13 1916
20. UNDERTAKER: Bruce Norstill
ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14065
Registered No. 26

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 104
City of Wallace (No. , River St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John C. McDiarmid

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH: July (Month) 8 (Day) 1865 (Year)
7. AGE: 60 yrs. 7 mos. 8 ds. IF LESS than 1 day how many.....hrs. or .....min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry business or establishment in which employed (or employer): Mercantile
9. BIRTHPLACE (State or Country): Canada
10. NAME OF FATHER: John McDiarmid
11. BIRTHPLACE OF FATHER (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Jane MacElman
13. BIRTHPLACE OF MOTHER (State or Country): Canada
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Vorstell
(Address) Wallace Ida
15. Filed Feb 19 1916 F Leo Dunfey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 16th (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 9th 1916, to Feb 16th 1916
that I last saw him alive on Feb 16th 1916
and that death occurred on the date stated above, at 6.30 P.M.
The CAUSE OF DEATH* was as follows:
Chr. Parenchymatous Nephritis
Sc Uraemia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteriosclerosis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wm T. Brandt M. D.
FEB 19 1916 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place 206 River St of death ....yrs. ....mos. 7 ds. In the town of Wallace State 30 yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death? Kellogg Idaho
Former or usual residence Kellogg Idaho

19. PLACE OF BURIAL OR REMOVAL: Spokane, Wash — DATE OF BURIAL: Feby 19 1916
20. UNDERTAKER: Bruce G. Worstell — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14066

Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 70

Primary Registration District No. 1961

County of Shoshone

City of Wallace (No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Otto Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 45 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teamster
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. E. Ward
(Address) Wallace Ida

15. Filed Feb 23 1916 F Leo Smyth Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
2 (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1916, to Febry 20 1916, that I last saw him alive on Feb 5 1916, and that death occured on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:
Hepatic Chunks
Chronic Nephritis

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary) Uraemia

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. A. Dr... M. D.

Feb 21 1916 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Wallace Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Feb 23 1916

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14068
Registered No. 23

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1071
(No. Providence Hosp St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Margaret F. Gearon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Apr (Month) 23 (Day) 1907 (Year)

7. AGE: 8 yrs. 10 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James Gearon

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: F. Curtin

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Theresa Gearon
(Address) Wallace Ida

15. Filed FEB 11 1916 191 ... F. Leo Lundy, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby. (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1916, to Feb 10 1916
that I last saw her alive on Feb 9 1916
and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
a Meningo-encephalitis

(Duration) ... yrs. ... mos. 6 ds.

Contributory (Secondary)
(Duration) 2 yrs. 2 mos. ... ds.

(Signed) J. W. Mowry M. D.
Feb 11 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the town of Wallace State 8 yrs. 10 mos. 16 ds.
Where was disease contracted, if not at place of death? yes
Former or usual residence: Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho
DATE OF BURIAL: Feby 12 1916.

20. UNDERTAKER: Bruce G. Worstell
ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14069

Registered No. 20

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 101
(No.) Providence Hospital (St.)

2. FULL NAME James Garfield Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
(Month) (Day) (Year): 1

7. AGE: 34 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mining Engineer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: J. C. Smith

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W. J. Berglund
(Address): Wallace Ida.

15. Filed FEB 2 1916 191 — H. Leo Lumley, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
(Month) (Day) (Year): Jan 31 1916

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1916, to Jan 31 1916
that I last saw him alive on Jan 30 1916
and that death occurred on the date stated above, at 7.30 P.M.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(Duration) ... yrs. ... mos. 10 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) H. Leo Lumley M. D.
Feb 2 1916 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place Providence Hosp. In the Town of Wallace
of death ... yrs. ... mos. 5 ds. State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? Wallace
Former or usual residence: Wallace Ida.

19. PLACE OF BURIAL OR REMOVAL: Portland, Ore.
DATE OF BURIAL: 2/3 1916

20. UNDERTAKER: K. G. Worstell
ADDRESS: Wallace Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14070

Registered No. 31

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 70

Primary Registration District No. 104

County of Shoshone

City of Wallace (No. Hope Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W. Travis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Aug (Month) 24 (Day) 1839 (Year)

7. AGE: 77 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Abraham Travis

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Sarah Crowder

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. L. Peters
(Address) Wallace, Ida

15. Filed Feb 6 1916 — F. Leo Trimper, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/24/15 1915, to Jan 1 1916, that I last saw him alive on Jan 1 1916, and that death occured on the date stated above, at 6.50 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 1 Yrs. — mos. 6 ds.

Contributory (Secondary): Railroad accident

(Duration) yrs. 8 mos. 9 ds.

(Signed) Fernand E. Jensen M. D.

1/16/16 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2 days. In this State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Residence

Former or usual residence: Same, Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Feb 6 1916

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14071
Registered No. 202

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace 1st Precinct)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eric Hanson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 36 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. E. Ward
(Address) Wallace Ida.

15. Filed Feb 8 1916 F Leo Sundquist Local Registrar

BYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3rd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st 1916, to Feb 3rd 1916, that I last saw him alive on Feb 3rd 1916, and that death occured on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Exposure
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. E. St Jean M. D.
Feb 1916 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? Black Bear
Former or usual residence Black Bear Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Feb 8 1916

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

M V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14072

Registered No. 20

PLACE OF DEATH.

County of Shoshone

City of Wallace (No. Providence Hosp't St.)

Registration District No. 20

Primary Registration District No. 204

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nisse Aho

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 32 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Timberman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: nisse aho

11. BIRTHPLACE OF FATHER (State or Country): Finland Mar 15

12. MAIDEN NAME OF MOTHER: Mathilda Saari

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Victor Fredrikson
(Address) Gem Idaho

15. Filed Mch 16 1916 F Leo Jundy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 6 1916, to Mar 11 1916, that I last saw him alive on Mar 11 1916, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Fracture of Skull
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) L Mowery M. D.
1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence: Mullans Ida

19. PLACE OF BURIAL OR REMOVAL: Mullan — DATE OF BURIAL: Mar 16 1916

20. UNDERTAKER: Ward Hud Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14073

Registered No. 37

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 10N

(No. Wallace Stockyard)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Aino Saari

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 20 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: John Saari

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Helma Katela

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) X Wilma Saari

(Address) Black Bear

15. Filed March 22 1916 F Leo Sundy Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 17 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7 1916, to March 17 1916, that I last saw h— alive on March 17 1916 and that death occured on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Britton M. D.

March 22 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Black Bear.

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Mar 22 1916

20. UNDERTAKER: Ward Hud Co — ADDRESS: Wallace Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Nez Perce — Registration District No. 9c

City of Lewiston — Primary Registration District No. 1009

(No. 1902 Main St.)

File No. 14074

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin Case

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Nov (Month) 9 (Day) 1842 (Year)

7. AGE: 74 Yrs. 4 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Iron Moulder
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Giles Case

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Tressie Butterfield

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) Emory Case

15. Filed 4-10- 1916 — L. J. Perkins, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/1/1916, to 3/12/1916, that I last saw h[illegible] alive on 3/11/1916, and that death occured on the date stated above, at 9:36 A. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. P. Hayes M. D.

3/2/1916 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 191

20. UNDERTAKER: [illegible] Hasson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 14075
Registered No. 29

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. Rubin Hotel Main St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Susie Whitman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 5 (Day) 1895 (Year)

7. AGE: 20 Yrs. 5 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: scholar
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lapwai Ida

10. NAME OF FATHER: Silas Whitman

11. BIRTHPLACE OF FATHER (State or Country): Komiah Ida,

12. MAIDEN NAME OF MOTHER: Sophie Thomas,

13. BIRTHPLACE OF MOTHER (State or Country): Indian Territory

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Silas Whitman
(Address) Spalding Ida

15. Filed 4-10- 1916 L.J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12 1916, to March 26 1916, that I last saw h[er] alive on March 26 1916, and that death occured on the date stated above, at 4.45 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 1 Yrs. 6 mos. ds.
Contributory (Secondary) General Tuberculosis
(Duration) yrs. mos. ds.

(Signed) E. G. Whitney M. D.
3-29 1916 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spalding Ida — DATE OF BURIAL ....191....

20. UNDERTAKER: [illegible] — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9c
Primary Registration District No. 1009
File No. 14076
Registered No. 30

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 427 Edwards St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah E. Griswold

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. Aug (Month) 23 (Day) 1 (Year)
7. AGE: 64 Yrs. 7 Mos. 5 ds. IF LESS than 1 day how many .....hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): Pa.
10. NAME OF FATHER: James Linsley
11. BIRTHPLACE OF FATHER (State or Country): Not known
12. MAIDEN NAME OF MOTHER: C Bitner
13. BIRTHPLACE OF MOTHER (State or Country): not known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Clara Hall
(Address).....
15. Filed 4-10- 1916. L. J. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 28- (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar. 12 1916, to Mar. 28 1916, that I last saw her alive on Mar 28 1916 and that death occured on the date stated above, at 12-20 noon M.
The CAUSE OF DEATH* was as follows:
Diabetes
Not known
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) L. J. Parker M. D.
3/28 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Idaho	Mar 30 1916
20. UNDERTAKER: C J Vasson	ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of ....

City of ....

Registration District No. 96

Primary Registration District No. 1009

(No. 523 E 2nd St.)

File No. 14077

Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mark Lucy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Quinana	Single

6. DATE OF BIRTH. Feb 1 [illegible] (Month) (Day) (Year)

7. AGE 67 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Chile

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ....

(Address) Long Barn

15. Filed 4-10- 1916 L J Parkin Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 28 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Consumption to Mch 20th 1916, that I last saw him alive on Mch 28th 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows: Consumption

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ....

(Duration) ... Yrs. ... mos. ... ds.

(Signed) M. Romero M. D.

19 .... (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL Lewiston Idaho — DATE OF BURIAL Mar 29 1916

20. UNDERTAKER C J Vassar — ADDRESS Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14078

Registered No. 31

1. PLACE OF DEATH.

County of Bannock

City of Ida Falls

(No. ....., ... St.)

Registration District No. 77

Primary Registration District No. 2 1 4 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Weaver

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Feby (Month) 21 (Day) 1916 (Year)

7. AGE: 0 Yrs. 1 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho Falls Ida

10. NAME OF FATHER M. A. Weaver

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Bertha Simpson

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L J Weaver

(Address) Idaho Falls, Ida

15. Filed April 1 1916 Copy [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/11/16 1916, to 3/27 1916, that I last saw h— alive on 3/27 1916 and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... Yrs. ..... mos. ..... ds.

(Signed) J. Hollister M. D.

19..... (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: 3/31 1916

20. UNDERTAKER: C G Dennoodey — ADDRESS: Idaho Falls

SYMS - YORK CO., PTRS. & BOKS. 24658

Hollister

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 4 7
(No. ....., ... St.)

File No. 14079
Registered No. 30

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elden Gill Poulter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH.
May (Month) 18" (Day) 1914 (Year)

7. AGE
1 Yrs. 10 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Shelley, Ida
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Shelley Ida

10. NAME OF FATHER Frank Poulter

11. BIRTHPLACE OF FATHER (State or Country) Ogden, Ut

12. MAIDEN NAME OF MOTHER Mary M. Gill

13. BIRTHPLACE OF MOTHER (State or Country) Ogden, Ut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Poulter
(Address) .....

15. Filed Apr 1 1916
Local Registrar

SVMS - YORK CO., PTRS. & SONS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/11/16 191..., to 3/27/16 191..., that I last saw h... alive on 3/27/16 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

3/ 1916 (Signed) J. Hollister M. D.
(Address) Ida Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ida Falls, Ida
DATE OF BURIAL: 3/29 1916

20. UNDERTAKER: E E Dimmoodey
ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Hollister

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73

Primary Registration District No. 2117

File No. 14081

Registered No. 23

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Bowcutt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Nov. 5 1854 (Month) (Day) (Year)

7. AGE: 57 Yrs. 4 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Thomas Bowcutt

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Eliz Powell

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. F. Williams

(Address) Idaho Falls

15. Filed Mar 11 1916 Compared Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1916, to Mar 11 1916, that I last saw h[illegible] alive on Mar 10 1916, and that death occured on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Fuller M. D.

3/11 1916 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby Idaho — DATE OF BURIAL: Mar. 12 1916

20. UNDERTAKER: G. R. Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14082

Registered No. 27

Registration District No. 73

Primary Registration District No. 2170

(No. ..... St.)

1. PLACE OF DEATH.

County of Bannock

City of Ida Falls

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Mrpkin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. April (Month) 24 (Day) 1913 (Year)

7. AGE: 2 Yrs. 10 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho Falls

10. NAME OF FATHER E. S. Mrpkin

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Delia Oltmanns

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C E Dimmoodey

(Address) .....

15. Filed Mar 11 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

accidental: Foreign body in wind pipe - strangulated.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Dimmoodey M. D.

3/ 19/6 (Address) Ida Falls, Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls

DATE OF BURIAL: 3/8 1916

20. UNDERTAKER: C E Dimmoodey

ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2107
File No. 14083
Registered No. 26

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gertrude Jane Palmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. January (Month) 3 (Day) 1900 (Year)

7. AGE: 16 Yrs. 2 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Park City - Utah

10. NAME OF FATHER: Asa Palmer

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Hannah Bates

13. BIRTHPLACE OF MOTHER (State or Country): Park City - Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C E Dimmoody
(Address) Idaho Falls

15. Filed Mar 28 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 23 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 10 1916, to Mar 23 1916, that I last saw her alive on Mar 21 1916, and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Endometritis. valvular insufficiency

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) S. S. Fuller M. D.
3/28 1916 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Milo Idaho — DATE OF BURIAL: 3/26 1916

20. UNDERTAKER: C E Dimmoody — ADDRESS: Ida Falls

Dr Fuller.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SURS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14084
Registered No. 27

1. PLACE OF DEATH. Registration District No. 73
County of Bonneville Primary Registration District No. 2170
City of Ozone (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Estella Bushnell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Mar. (Month) 8 (Day) 1916 (Year)

7. AGE ....Yrs....Mos. 7 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): /

9. BIRTHPLACE (State or Country) Ozone, Ida.

10. NAME OF FATHER Cyrus E. Bushnell

11. BIRTHPLACE OF FATHER (State or Country) Do. Dakota

12. MAIDEN NAME OF MOTHER Mary Olson

13. BIRTHPLACE OF MOTHER (State or Country) Do. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C E Bushnell
(Address) Ozone Idaho

15. Filed Mr 27 1916 Geo. Fremont Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. (Month) 15 (Day), 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....1916...., to ....1916....,
that I last saw h....alive on ....1916....,
and that death occured on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:
Unknown.
No medical attendant
available in the dry farm.
(Duration) ....Yrs. / mos. ....ds.
Contributory (Secondary) ....
(Duration ....yrs. ....mos. ....ds.
(Signed) Geo Fremont M. D.
....1916.... (Address) Ozone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Ozone — DATE OF BURIAL: Mar. 17, 1916

20. UNDERTAKER: None — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 3-15 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14085

Registered No. 24

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville Registration District No. 73

City of Ozone (No. ....., ... St.) Primary Registration District No. 2170

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eldora Bushnell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Mar. (Month) 8 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ozone.

10. NAME OF FATHER: Cyrus E. Bushnell

11. BIRTHPLACE OF FATHER (State or Country): So. Dakota

12. MAIDEN NAME OF MOTHER: Mary Olson

13. BIRTHPLACE OF MOTHER (State or Country): So. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C E Bushnell

(Address) Ozone Idaho

15. Filed Nov 24 1916 Geo. J. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. (Month) 8 (Day), 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Unknown

No medical attendant available on dry farm

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Johnson M. D.

19..... (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ozone — DATE OF BURIAL: Nov. 8 1916

20. UNDERTAKER: None — ADDRESS:

BYRNS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-15

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2110
(No. ..... , ... St.)

File No. 14086
Registered No. 29

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Mary Faber

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: July (Month) 15 (Day) 1837 (Year)

7. AGE: 78 Yrs. 8 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: ~~Anna~~ Martin Fitzgerald

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna Marie Aronoldi

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Marie Frew
(Address) Ida Falls

15.
Filed Mch 1 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 26 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 14 1916, to Mch 26 1916, that I last saw her alive on Mch 26 1916, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 2 Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) C. E. Lewis M. D.

Mch 26 1916 (Address) Ida Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Ship...

19. PLACE OF BURIAL OR REMOVAL: Fostoria, Ohio
DATE OF BURIAL: 3/28 1916

20. UNDERTAKER: C E Dinwoodey
ADDRESS: Ida Falls

8-VMS - YORK CO., PTG. & SDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14087

Registered No. 32

1. PLACE OF DEATH.

County of Bannock

City of Ida Falls

Registration District No. 73

Primary Registration District No. 2110

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME O. F. Eastman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 18 (Day) 1828 (Year)

7. AGE: 87 Yrs. 4 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Vermont, U.S.

10. NAME OF FATHER James Eastman

11. BIRTHPLACE OF FATHER (State or Country) Vermont

12. MAIDEN NAME OF MOTHER C. Goss

13. BIRTHPLACE OF MOTHER (State or Country) Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Byboer

(Address) Twin Falls Ida

15. Filed Apr 1 1916

Local Registrar

SYMS - YORK PRT'G. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 24 1916, to March 26 1916, that I last saw him alive on 3/24 1916, and that death occured on the date stated above, at 5 P- M.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchi

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. S. Fuller M. D.

19..... (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls, Ida — DATE OF BURIAL: 3/29 1916

20. UNDERTAKER: E. E. Dinwoodey — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2112
(No. ....., ... St.)

File No. 14088
Registered No. 33

1. PLACE OF DEATH.
County of Canewell
City of Ida Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chester Wilbur Breckinridge
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 12 1883
(Month) (Day) (Year)

7. AGE: 33 Yrs. 0 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Frank Breckinridge

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mattie Nissler

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R Milligan
(Address) Ida Falls

15. Filed Feb 1 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 25 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gun Shot Wounds from unknown hands - Not his own

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C C Dunnaday Coroner M. D.
19..... (Address) Ida Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence ..... Idaho

19. PLACE OF BURIAL OR REMOVAL: La Grande, Ore. DATE OF BURIAL: 3/28 1916

20. UNDERTAKER: C C Dunnaday ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 0 0
(No. ....., ... St.)

File No. 14089
Registered No. 34

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Pennyrille
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John L Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH. (Month) Sept (Day) 12 (Year) 1846

7. AGE: 69 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Mat Penner

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John L Miller
(Address) Idaho Falls Ida

15. Filed April 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 3- (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1916, to April 1916, that I last saw him alive on April 3 1916, and that death occured on the date stated above, at 5 P M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Hardening of arteries
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G W Pendleton M. D.
19..... (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pine Hill Cem — DATE OF BURIAL: April 6 1916

20. UNDERTAKER: W Ladd — ADDRESS: Idaho Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2133

File No. 14090

County of Bonner

City of Sandpoint (No. ....., ... St.)

Registered No. 877

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dolby Jenkins

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: July 11 1914 (Month) (Day) (Year)

7. AGE: 1 yrs. 9 mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Everett Jenkins

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Minnie Hagerty

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Everett Jenkins

(Address) Heron Mont

15.

Filed Apr 11 1916 M. V. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr 10 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 5 1916, to Apr 10 1916, that I last saw her alive on Apr 10 1916, and that death occurred on the date stated above, at 8 30 P.M.

The CAUSE OF DEATH* was as follows:

Grippe - (Probably streptococcic) 14 days -

Cerebro spinal meningitis

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Strackhouse M. D.

4-11-1916 (Address) Sand Point, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Heron Mont

DATE OF BURIAL: Apr 12 1916

20. UNDERTAKER: E. M. Broome

ADDRESS: [illegible]

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2155

File No. 14091

Registered No. 876

County of Bonner

City of Sandpoint (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME A. A. Walters

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

6 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. M. Brown Sr.

(Address) Sandpoint Ida

15.

Filed April 6 1916 M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr. 4 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Suicide

Gun Shot Wound.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Knapp M. D.

4/5 1916 (Address) Hope, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Ida	4/12 1916

20. UNDERTAKER	ADDRESS
E. M. Brown Sr.	S. P.

If death occurs away from usual residence, give facts called for under special information. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2155

File No. 14092

County of Bonner

City of Sandpoint (No. ....., ... St.)

Registered No. 838

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Shoemaker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	M

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

62 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Laborer

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph Bray

(Address) Sandpoint

15.

Filed Apr 16 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr 15 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Spring of 1914, to Apr 15 1916, that I last saw him alive on Apr 13 1916, and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Uremia - Chronic Nephritis

..... (Duration) Several yrs. ..... mos. ..... ds.

Contributory (Secondary) Caused by Alcoholism

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R V Jameson M. D.

19 ..... (Address) Sandpoint.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Priest River	Apr 16 1916

20. UNDERTAKER	ADDRESS
C M Bonner	L P

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2133

File No. 14093

City of Sand Point (No. ....., ... St.)

Registered No. 872

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Gravelle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

61 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Barkeeper

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE —
(State or Country)

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER —
(State or Country)

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER —
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C M Brown

(Address) Sand Point

15.

Filed Apr 24 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 22 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Summer 1912, to Apr 22 1916, that I last saw h Living alive on Apr. 21 1916, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Fatty heart. Arteriosclerosis. Nephritis
Cirrhosis of liver —
"General fibrosis"

(Duration) 3 yrs. ..... mos. ..... ds.

Contributory (Secondary) Hard drinker for years

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R T Isaacson M. D.

19 ..... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sand Point Idaho — DATE OF BURIAL: 5/6 1916

20. UNDERTAKER: C M Brown — ADDRESS: SP

SYMS - YORK CO., PTRS. & BDRS. 19760

Send State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIAN carefully supplied.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Mac

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2135

File No. 14094

City of Sandpoint (No. ....., ... St.)

Registered No. 880

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William L Davis

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Nov (Month) 13 (Day) 1865 (Year)

7. AGE: 51 yrs. 1 mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: A. M. Davis

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Cordelia Burgess

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A. M. Davis
(Address) Sandpoint Ida Co

15.
Filed April 24 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1912 to July 1912 that I last saw him alive on Sept 1915 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Abscess of Lung
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. McKinnon M. D.
Apl 24 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: Apr 25 1916

20. UNDERTAKER: E M Brown — ADDRESS: S P

SYMS - YORK CO., PTRS. & SORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2133

File No. 14095

City of Sandpoint (No. ....., ... St.)

Registered No. 881

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella Langhoff

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Feb. (Month) 18 (Day) 1840 (Year)

7. AGE: 71 yrs. 2 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: John Haney

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Henrietta —

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Langhoff
(Address) Sandpoint Ida

15. Filed April 29 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1916, to Apr 28 1916, that I last saw her alive on March 30 1916, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Cancer stomach (pylorus)
secondary to
Cancer Uterus.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Strackbone M. D.

4-29 1916 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane Wn	May 1 1916
20. UNDERTAKER	ADDRESS
E M Brown	S P.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2135

File No. 14096

County of Bonner

City of Sandpoint (No. ....., ... St.)

Registered No. 882

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nels Anderson Lund

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Married

6. DATE OF BIRTH: Sept (Month) 11 (Day) 1857 (Year)

7. AGE: 58 yrs. 6 mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mill Wright
(b) General nature of industry business, or establishment in which employed (or employer): repairing Saw. mill

9. BIRTHPLACE (State or Country): Arvika Sweden

10. NAME OF FATHER: Andrew Lund

11. BIRTHPLACE OF FATHER (State or Country): Arvika Sweden

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herman Burke
(Address) Sandpoint Idaho

15. Filed Mar 30 1916 M McKinna Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1916, to March 29 1916, that I last saw h[illegible] alive on March 29 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.

March 30 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint	Apr 2 1916
20. UNDERTAKER	ADDRESS
E McKinnon	[illegible]

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14098

Registered No. .....

1. PLACE OF DEATH.

County of Ada

City of R F D Kuna

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edwin Pearl Curtis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Mar (Month) 23 (Day) 1915 (Year)

7. AGE: 1 Yrs. — Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... —

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER P. C. Curtis

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Mabel Brown

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. C. Curtis

(Address) Kuna Ida

15. Filed 4/18 1916 R F D F L McCauley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 17th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 16 1916, to Apr 17 1916, that I last saw him alive on Apr 17 1916, and that death occured on the date stated above, at 11A M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. 6 ..... ds.

(Signed) F. L McCauley M. D.

4/18 1916 (Address) Kuna Ida Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kuna Cem.

DATE OF BURIAL: 4/17 1916

20. UNDERTAKER: Had none

ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 216
File No. 4
Registered No. 14099

1. PLACE OF DEATH.
County of Bannock
City of Bancroft
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew P. Hansen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Apr (Month) 9 (Day) 1849 (Year)

7. AGE: 67 yrs. 1 mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Hans Mortensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Cecile Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Hansen
(Address) Central. Ida.

15. Filed 4/27 1916 Dr. P. J. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 3 1916, to Apr 23 1916, that I last saw h[im] alive on Apr 23 1916, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Asthenia from Cardio-vascular-renal disease
(Duration) 4 yrs. mos. ds.
Contributory (Secondary) Pneumonia Lobar
(Duration) yrs. mos. 4 ds.

(Signed) Russell J. Smith M. D.
4/27 1916 (Address) Bancroft Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Central. Ida.
DATE OF BURIAL: 4/25 1916

20. UNDERTAKER
ADDRESS

SYMS-YORK CO., PRINTERS & RINDERS. BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 63
Primary Registration District No. 2143
File No. 14100
Registered No. 27

1. PLACE OF DEATH.
County of Latah
City of Juliaetta (No. ....., ... St.)
If death occurs away from usual residence give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benjamin F Stevens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: July (Month) 25 (Day) 1822 (Year)

7. AGE: 93 yrs. 8 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Ellen Adams relative
(Address) Juliaetta Ida

15. Filed Apr 9 1916 J E Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22 1915, to April 8 1916, that I last saw him alive on Apr 8 1916, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Senile Weakness

(Duration) 4 yrs. — mos. — ds.

Contributory (Secondary) a Fall Dec 22 1915

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Hoyt M. D.
Apr 9 1916 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Juliaetta Ida
DATE OF BURIAL: Apr 10 1916

20. UNDERTAKER: E. E. Bechtol
ADDRESS: Kendrick Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. [redacted] 1-16-12

CERTIFICATE OF DEATH

61

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1011

County of Latah

Primary Registration District No.

City of Moscow (No. , Gailand Hospital St.)

File No. 14101

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilbur Winfred Edmundson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: March (Month) 10 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many 10 hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Moscow Idaho

10. NAME OF FATHER Wilbur Clifford Edmundson

11. BIRTHPLACE OF FATHER (State or Country) Moscow Idaho

12. MAIDEN NAME OF MOTHER Alta Taylor

13. BIRTHPLACE OF MOTHER (State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. C. Edmundson

(Address) Moscow

15. Filed 3-11-1916 S. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1916, to March 11" 1916, that I last saw him alive on March 10 1916, and that death occurred on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Carothers M. D.

March 11 1916 (Address) Moscow Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 10 Hrs. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	3/11 1916

20. UNDERTAKER	ADDRESS
Glen E Grice	Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 3141
File No. 14102
Registered No. 37

1. PLACE OF DEATH.
County of Latah
City of 11 Miles southeast of Moscow (If not in city or town give township) (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Etta Amanda Hatton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 22 (Day) 1883 (Year)

7. AGE: 32 yrs. 4 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Elmer L. Ludlam

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Amelia Robertson

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Calvin R Hatton
(Address) Moscow

15. Filed April 1 1916 D F Bal
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-18 1916, to 3-30 1916, that I last saw her alive on 3-30 1916, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Puerperal Septicemia

(Duration) yrs. mos. 16 ds.
Contributory (Secondary) Chronic Interstitial Nephritis
(Duration) 8 yrs (?) mos. ds.

(Signed) John A Dodd M. D.
3-31 1916 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: April 1st 1916

20. UNDERTAKER: Glen O Grice
ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BORS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 14103

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ..... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Anna Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. August (Month) 28 (Day) 1840 (Year)

7. AGE: 75 Yrs. 7 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Connor

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward O Franklin
(Address) moscow

15. Filed Oct 28 1916
E F Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend her 191..., to ..... 191...,
that I last saw h.s alive on April 26 1916,
and that death occured on the date stated above, at 12.45 A.M.

The CAUSE OF DEATH* was as follows:
Old Age

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) J. N. Clarke M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Oct 30 1916

20. UNDERTAKER: Geo O Price — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 14104
Registered No. 29

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. 328, 2nd St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Zalora A. Cozier

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Oct (Month) 2 (Day) 1838 (Year)

7. AGE: 77 yrs. 6 mos. 21 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: William Carter

11. BIRTHPLACE OF FATHER (State or Country): Conn

12. MAIDEN NAME OF MOTHER: Anna Van Alsdale

13. BIRTHPLACE OF MOTHER (State or Country): Conn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mark Cozier
(Address) Moscow Idaho

15. Filed Apr. 24 1916 J. T. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 23d (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20th 1916, to April 23 1916, that I last saw her alive on April 22d 1916, and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:
Senility

(Duration) ....yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. R. Cedar M. D.
April 24 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: April 25 1916

20. UNDERTAKER: Glen Price
ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14105
Registered No. 28

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)

Registration District No. 61
Primary Registration District No. 1011

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Shelby Griffith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~SINGLE, MARRIED~~, WIDOWED OR ~~DIVORCED~~. (Write the word.): Widowed

6. DATE OF BIRTH: Sept 4 1833 (Month) (Day) (Year)

7. AGE: 82 yrs. 7 mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Benj. Griffith

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. W. Gregg
(Address) Viola Ida

15. Filed Apr 19 1916 J. H. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 16 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1915, to April 15 1916
that I last saw him alive on April 12 1916
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Endocarditis

..... (Duration) ..... yrs. 6 mos. — ds.
Contributory (Secondary) Old Age
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Clarke M. D.
..... 19 ..... (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Viola — DATE OF BURIAL: Apr 19 1916

20. UNDERTAKER: Ed Anderson — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. Orchard Ave. & F St.)

File No. 14106
Registered No. 31
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Isabel Hunting

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Nov (Month) 30 (Day) 1907 (Year)

7. AGE: 8 yrs. 4 mos. 4 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alberta Canada

10. NAME OF FATHER: Harvey H Hunting

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Anna Cook

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H H Hunting
(Address) Moscow Idaho

15. Filed Apr 5 1916 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 3 (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1915, to March 1916, that I last saw her alive on Oct 15 1915, and that death occurred on the date stated above, at 9 45 P.M.

The CAUSE OF DEATH* was as follows:
Suffers from tubercular hip Joint

(Duration) 2 yrs. mos. ds.

Contributory (Secondary) Injury to Joint from a fall

(Duration) yrs. mos. ds.

(Signed) W. C. Adair M. D.
April 4 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: April 5 1916

20. UNDERTAKER: Glen A Price
ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
(No. ..... St.)

File No. 14107
Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Latah
City of Moscow

2. FULL NAME Alfred Ray Cameron

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Mch (Month) 14 (Day) 1895 (Year)

7. AGE
20 Yrs. 11 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER William T. Cameron

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Louisa Martin

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. T. Cameron
(Address) Moscow

15. Filed 3/9 1916 L. F. Rae Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1916, to March 7 1916, that I last saw him alive on March 7 1916, and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Spinal Meningitis
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Injury about Jan 20-1916
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Joseph Asprey M. D.
19.... (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 11 days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? At home
Former or usual residence Was Moscow Ida.

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 3/9 1916

20. UNDERTAKER: Glen O. Grice — ADDRESS: Moscow

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 2151

File No. 14108

County of Idaho

City of County Farm (No. ....., ... St.)

Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John W. Eraser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	widower

6. DATE OF BIRTH: January (Month) 12th (Day) 1846 (Year)

7. AGE: 70 yrs. 3 mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rochester New York

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno. W. Eraser.
(Address) Boise

15. Filed May 5 1916 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1916, to April 26 1916, that I last saw him alive on April 25 1916, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) unknown yrs. mos. ds.

Contributory (Secondary) Valvular disease of heart

(Duration) unknown yrs. mos. ds.

(Signed) G S Stockton M. D.

4/26 1916 (Address) Granville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: April 27 1916

20. UNDERTAKER: E Hancock — ADDRESS: Granville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Greencreek
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181
(No. ....., ... St.)

File No. 14109
Registered No. 13

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Jennie Hamill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: June (Month) 24 (Day) 1856 (Year)

7. AGE: 59 yrs. 10 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: House Wife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: A. R. Henderson

11. BIRTHPLACE OF FATHER (State or Country): Kentuckey

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. W. Hamill
(Address) Greencreek

15.
Filed May 5 1916 G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1916, to April 21 1916 that I last saw her alive on April 21 7 A.M. 1916, and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Splenomedullory leukaemia

(Duration) 1 yrs. 6 mos. ds.
Contributory (Secondary) Bronchial Pneumonia
(Duration) yrs. mos. 2 ds.

(Signed) J. D. Shinnick M. D.
April 21 1916 (Address) Collinwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View
DATE OF BURIAL: April 23 1916

20. UNDERTAKER: W E Graham
ADDRESS: Orangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 57
Primary Registration District No. 2164
(No. ....., ... St.)

File No. 14111
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Washington
City of Cambridge
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. April (Month) 3 (Day) 1916 (Year)
7. AGE: .....Yrs. .....Mos. 14 ds. IF LESS than 1 day how many .....hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Washington Co
10. NAME OF FATHER: Dave Scobee
11. BIRTHPLACE OF FATHER (State or Country): .....
12. MAIDEN NAME OF MOTHER: Della Weston
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C E Schmuck
(Address) Cambridge Idaho
15. Filed May 1 1916 C E Schmuck, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 17 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 191..., to April 17 1916, that I last saw h[illegible] alive on April 191..., and that death occured on the date stated above, at 7 P M.
The CAUSE OF DEATH* was as follows:
Premature birth Immaturity
.....(Duration) .....Yrs. .....mos. 14 ds.
Contributory (Secondary) .....
.....(Duration) .....yrs. .....mos. .....ds.
(Signed) C E Schmuck M. D.
April 17 1916 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Valentine Idaho — DATE OF BURIAL: April 18 1916
20. UNDERTAKER: Jas Hendelson — ADDRESS: Ida Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, FRACTIONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14112

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 88

Primary Registration District No. 2164

County of Adams

City of Indian Valley (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hardwell & Westfall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Aug (Month) 4 (Day) 1857 (Year)

7. AGE: 65 Yrs. 4 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: James Westfall

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Elizabeth Knibley

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alice A Westfall
(Address) Mesa

15. Filed April 20 1916 O E Schmutz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3 1916, to April 17 1916, that I last saw h.. alive on April 16 1916, and that death occured on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Edema of Lungs

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) Cardiac Dilatation

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) O E Schmutz M. D.

April 20 1916. (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Valley — DATE OF BURIAL: April 18 1916

20. UNDERTAKER: J A Anderson — ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK.

SYMS - YORK CO., PTRS. & BORS. 24654

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 87

Primary Registration District No. 2164

File No. 14113

Registered No. .....

1. PLACE OF DEATH.

County of Washington

City of Cambridge

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lovina Robenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. April (Month) 23 (Day) 1830 (Year)

7. AGE: 85 Yrs. 11 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Huff

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella L Ensegen

(Address) Cambridge Idaho

15. Filed May 1 1916 — O E Schmutz, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1916, to Mar 29 1916, that I last saw h— alive on Mar 29 1916, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 3 Yrs. 4 mos. 11 ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O E Schmutz M. D.

May 1 1916 (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho — DATE OF BURIAL: Mar 31 1916

20. UNDERTAKER: Jas Hendelman — ADDRESS: Cambridge Ida

BYNUM - YORK CO., PTRS. & BDRS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 92

County of Ada-Canyon

Primary Registration District No. 2170

City of Summit, Ida.

(No. ....., ... St.)

File No. 4 34114

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Illick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April 27 — 1884
(Month) (Day) (Year)

7. AGE: 31 yrs. 11 mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Machine -
(b) General nature of industry business, or dstablishment in which employed (or employer): Blacksmith

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Austria.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Churnak

(Address) Summit, Ida.

15. Filed 4-21 1916 E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April — 20th — 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10th 1916., to April 20th 1916., that I last saw him alive on April 10th — 1916, and that death occurred on the date stated above, at 7. P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. ✓ mos. ✓ ds.

Contributory (Secondary) Pneumonia

(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) J. J. Harrington M. D.

19.... (Address) Gifford Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Chicago	191

20. UNDERTAKER	ADDRESS
W. E. Stoddard	Gifford Ida

CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Erasures, alterations or illegible entries will cause delay. Physicians are requested to fill out this certificate. ment of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 14115
Registered No. .....

1. PLACE OF DEATH.
County of Benewah.
City of Plummer.
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maggie Estell Lowrey.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Aug. (Month) 31 (Day) 1911 (Year)

7. AGE
4 Yrs. 7 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Mitchell Co N. Carolina

10. NAME OF FATHER: William Lowrey.

11. BIRTHPLACE OF FATHER
(State or Country) Michell. Co. N. Carolina

12. MAIDEN NAME OF MOTHER: Vonie Bartlett.

13. BIRTHPLACE OF MOTHER
(State or Country) Mitchell. Co. N. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15.
Filed April 14 1916. H L Hl.
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8th 1916, to April 13th 1916, that I last saw her alive on aplil 13th 1916, and that death occured on the date stated above, at 10-40 P.M.

The CAUSE OF DEATH* was as follows: Measles

(Duration) ..... Yrs, ... mos. 6 ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) S. A. Harrington. MD
April 13 1916. (Address) Plummer Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 15 days. In the State ..... yrs. ..... mos. 15 days
Where was disease contracted if not at place of death? Un-Known
Former or usual residence Mitchell Co. N. Carolina

19. PLACE OF BURIAL OR REMOVAL: Plummer — DATE OF BURIAL: April 14 1916

20. UNDERTAKER: Fairfield Degn — ADDRESS: Plummer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14116

Registered No. .....

1. PLACE OF DEATH.

County of Bonneville

City of Country

(No. ....., ... St.)

Registration District No. 82

Primary Registration District No. 2049

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Liliana May Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 17 (Day) 1896 (Year)

7. AGE: 20 Yrs. ..... Mos. X.S. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: W. E. Lewis

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Della Light

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. E. Lewis

(Address) St Maries

15. Filed April 13 1916 H. L. H. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 5 1916, to Apr 12 1916, that I last saw her alive on Apr 12 1916, and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Convulsions due to Spina Spinal or Cerebral trouble

(Duration) 7 Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration 4 yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Apr 14 1916 (Address) Cour D'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 4/14 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

SYMS - YORK CO., PTRS. & BOOKS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone — Registration District No. 32

City of Slate Creek — Primary Registration District No. 2049

(No. ....., ... St.)

File No. 14117

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jason F Caine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 12 (Day) 1878 (Year)

7. AGE: 37 Yrs. 5 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Armstead Caine

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Martha Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): Ken.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bert L Caine

(Address) St Maries

15. Filed April 13 1916 — H. L. M. Local Registrar

SVMS - YORK CO., PTRS. & SORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Struck by falling Tree

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Mowery Coroner

19..... (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: April 17 1916

20. UNDERTAKER: H E Smith — ADDRESS: St Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Benewah
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3 2
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 14118
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ross Franklin Harvey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Jan (Month) 17 (Day) 1894 (Year)

7. AGE
22 Yrs. 3 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Wireless operator
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) South Dakota

10. NAME OF FATHER
John T. Harvey

11. BIRTHPLACE OF FATHER
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER
Alice D. Merry

13. BIRTHPLACE OF MOTHER
(State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John T Harvey
(Address) Dell Rapids S.D.

15.
Filed 4/20 1916
H. L. [illegible]
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Died on Irving
Tuberculosis of Larynx
.....(Duration) ..... Yrs. 2 mos. — ds.
Contributory (Secondary)
.....(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. Longwell M. D.
4/19/16 (Address) St Maries Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dell Rapids S.D. DATE OF BURIAL: 4/20 1916

20. UNDERTAKER: H E Hunt ADDRESS: St Maries

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls — Registration District No. 38

City of Filer — Primary Registration District No. 2086

(No. ....., ... St.) — File No. 14119

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Lewis McKibbon

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M.	W.	

6. DATE OF BIRTH — Jan (Month) 6 (Day) 1911 (Year)

7. AGE — 2 yrs. 3 mos. 17 ds. — IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Walter McKibbon

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Blanche Price

13. BIRTHPLACE OF MOTHER (State or Country) Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter McKibbon
(Address) Filer Ida

15. Filed 4-13 1916 — A A Newberry — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH — Apl. (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191..., to ✓ 191...,
that I last saw h... ✓ alive on ✓ 191...,
and that death occurred on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:
Not determined — Sick 2 days —
Parents are Christian Scientists
Had no medical aid

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. A. Newberry M. D.

19.... (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — Filer Cemetery — DATE OF BURIAL 4-14 1916

20. UNDERTAKER — None (Father acted) — ADDRESS Filer Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2086
File No. 14120
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Filer (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pearl L Allender

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem.	W.	married

6. DATE OF BIRTH: Apl. (Month) 17 (Day) 1887 (Year)

7. AGE: 29 yrs. mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Logan Iowa

10. NAME OF FATHER: Joseph Copeland

11. BIRTHPLACE OF FATHER (State or Country): Indian

12. MAIDEN NAME OF MOTHER: Ida Frazier

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. J Allender
(Address) Filer Ida

15. Filed May 5 1916 aa Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl. 23 1916, to May 23 1916, that I last saw h. alive on May 5 1916, and that death occurred on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(Duration) yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) A A Newberry M. D.

19 (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Filer Cemetery	5-7 1916

20. UNDERTAKER	ADDRESS
F E Drake	Filer Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 2086
(No. ..... St.)

File No. 14121
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patrick William Navin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Apl. (Month) 6 (Day) 1860 (Year)

7. AGE: 56 yrs. ..... mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Davenport Ia

10. NAME OF FATHER: Dennis Navin

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Maria Nilsen

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C A Navin
(Address) Filer Ida

15. Filed Apl. 11 1916 C A Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apl. (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 7, 1916, to Apl. 11 1916, that I last saw h.m alive on Mar. 7 1916 and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 20 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C A Newberry M. D.

19..... (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Cem | DATE OF BURIAL: Apl. 13 1916

20. UNDERTAKER: L E Drake | ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14123

Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5
Primary Registration District No. 2131

2. FULL NAME Gertie Russell

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: April (Month) 5 (Day) 1892 (Year)

7. AGE: 24 yrs. 0 mos. 22 ds.
IF LESS than 1 day how many ... 6 hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) house-servant.

9. BIRTHPLACE (State or Country) Montpelier Ida.

10. NAME OF FATHER Fred Russell

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Mary Meier

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. W. Lynn
(Address) Montpelier Ida.

15. Filed April 30th 1916 J. H. Hoberg Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1915; to April 4th 1916 that I last saw her alive on April 4th 1916 and that death occurred on the date stated above, at 11 a.M.

The CAUSE OF DEATH* was as follows:
Endothelioma of the spinal cord, cervical region.
(Duration) yrs. 6 mos. ds.
Contributory (Secondary) Contusion pain
(Duration) yrs. 6 mos. ds.

(Signed) A. W. Lynn M. D.
(Address) Montpelier Ida.
April 27 1916

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier
DATE OF BURIAL: 4/30 1916

20. UNDERTAKER: Jarboe
ADDRESS: Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14124
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Potlatch
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65
Primary Registration District No. 2145
(No. ....., ... St.)

2. FULL NAME Matthew Dixon

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single.
6. DATE OF BIRTH: April (Month) 21 (Day) 1916 (Year)
7. AGE: ..... yrs. ..... mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Idaho.
10. NAME OF FATHER: Miles E Dixon
11. BIRTHPLACE OF FATHER (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Bertha Johnston.
13. BIRTHPLACE OF MOTHER (State or Country): Iowa
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miles. E. Dixon.
(Address) Potlatch Idaho
15.
Filed April 23 1916 D. J. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. (Month) 22 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr 21 1916, to Apr 22 1916, that I last saw him alive on Apr 21 1916, and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Respiration Obstruction
Acute Bronchitis. not tuberculous
..... (Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo I Boyd M. D.
Apr 22 1916 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery
DATE OF BURIAL: April 23 1916
20. UNDERTAKER: E Anderson
ADDRESS: Palouse Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
(No. ..... St.)

File No. 14125
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Potlatch
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sallie Gertrude Shamp[illegible]
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 4 (Day) 1916 (Year)

7. AGE: 20 Yrs. ..... Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A M Craig

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Lillie M Gilmore

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arthur M Craig
(Address) Princeton Idaho

15. Filed April 6 1916 J. M. Thompson Local Registrar

SVMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4 1916, to April 4 1916, that I last saw her alive on April 4 1916, and that death occured on the date stated above, at 10 30 M.

The CAUSE OF DEATH* was as follows:

Puerperal Uremia -

(Duration) ..... Yrs. ..... mos. 3 hrs.

Contributory (Secondary): Puerperal albuminuria

(Duration ..... yrs. 2 mos. ? ds.

(Signed) J. M. Thompson M. D.
4/6 1916 (Address) Potlatch Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch — DATE OF BURIAL: April 6 1916

20. UNDERTAKER: E Anderson — ADDRESS: Potlatch Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14126

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Palatch

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65

Primary Registration District No. 2145

(No. ..... St.)

2. FULL NAME Nicholas Kinsella

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. Mar (Month) 15 (Day) 1866 (Year)

7. AGE: 60 Yrs. 1 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Michael Kinsella

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Bertha Murphy

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lizzy Kinsella

(Address) Palatch Ida

15. Filed April 18th 1916 W. J. Thompson Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 25th (Day) 1916 (Year)

17. I HEREBY CERTIFY, ~~That I attended deceased from~~ 191 ~~to~~ 191, ~~that I last saw him alive on~~ 191, and that death occured on the date stated above, at 830 P M.

The CAUSE OF DEATH* was as follows:

during the unloading of logs from a flat car he was struck by a log and died at once - accidental

(Duration) ~ Yrs. ~ mos. ~ ds.

~~Contributory~~ (Secondary) Issued by order of Coroner of Latah County (Duration) ... yrs. ... mos. ... ds.

(Signed) Ed Stepp M. D.

4/27 1916 (Address) Palouse Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palatch Ida — DATE OF BURIAL: April 28 1916

20. UNDERTAKER: E Anderson — ADDRESS: Palouse Wn

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee
City of Drumeon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 44
Primary Registration District No. 2121
(No. ....., ... St.)

File No. 17 14127
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Dryden

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Aug. (Month) 16 (Day) 1915 (Year) (X)

7. AGE: 0 yrs. 8 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thos. N. Dryden

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ella Wilson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15.
Filed ..... 191....
J C Bartlett
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 16 1916, to Apr 19 1916, that I last saw her alive on Apr 19 1916 and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) ..... yrs. 6 mos. — ds.
Contributory (Secondary) Acute Indigestion
(Duration) 0 yrs. 0 mos. 3 ds.

(Signed) J C Bartlett M. D.
4/26 1916 (Address) Drumeon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Drumeon
DATE OF BURIAL: 4/20 1916

20. UNDERTAKER: J E Sears
ADDRESS: Drumeon Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6

Primary Registration District No.

File No. 14128

Registered No.

1. PLACE OF DEATH.

County of Gem

City of Emmett

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Duane Huntsinger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. (Month) Mar (Day) 2 (Year) 1915

7. AGE: Yrs. 1 Mos. 1 ds. 21

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Emmett Ida

10. NAME OF FATHER: James A Huntsinger

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Eliza Jane Cole

13. BIRTHPLACE OF MOTHER (State or Country): Grant Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James A Huntsinger

(Address) Emmett Idaho

15.

Filed 4/27 1916 J A Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Apr (Day) 25 1916

17. I HEREBY CERTIFY, That I attended deceased from Apr 16 1916, to Apr 25 1916, that I last saw him alive on Apr 24 1916, and that death occured on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Abscess of Lung

(Duration) Yrs. mos. ds.

Contributory (Secondary) Pneumonia

(Duration yrs. 10 days mos. ds.

(Signed) J A Reynolds M. D.

4/27 1916 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Cemetery — DATE OF BURIAL: 4/27 1916

20. UNDERTAKER: Darwin — ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

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SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Elmore
City of Emmett
(No. ..... St.)

Registration District No. 6
Primary Registration District No. 6

File No. 14129
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sin Ofsasatt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Do not Know
(Month) (Day) (Year)

7. AGE: 22 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep herder
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Do not Know

11. BIRTHPLACE OF FATHER (State or Country): " " "

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ventura Veristain
(Address) Boise Idaho

15.
Filed May 2 1914 J. L. Reynolds Local Registrar

SYMS - YORK CO., PRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
4 — 29 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-25- 1916, to 4-29 1916, that I last saw h[illegible] alive on 4-29 1916, and that death occured on the date stated above, at 10P M.

The CAUSE OF DEATH* was as follows:
Pneumonia Caused by Lungs
Probably Inflamed Stomach
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) B. O. Clark M. D.
5/2 1914 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 5/1 1916

20. UNDERTAKER: O Bucknum
ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5[illegible]6 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6

Primary Registration District No. .....

File No. 14130

Registered No. .....

1. PLACE OF DEATH.
County of Ada
City of Emmett
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susan Hyndman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Jan (Month) 29 (Day) 1837 (Year)

7. AGE 79 Yrs. 2 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER James Hyndsman

11. BIRTHPLACE OF FATHER (State or Country) Born on Atlantic Ocean

12. MAIDEN NAME OF MOTHER Sarah Fry

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. H. Swilegan
(Address) Emmett Idaho

15.
Filed 4/22/ 191 6
F. H. Reynolds Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 6 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
No physician in attendance
Dr Cummings saw deceased one week ago.
Senility no doubt cause of death

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C D Bucknum

..... 19..... (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 4/9 191 6

20. UNDERTAKER: C D Bucknum
ADDRESS: Emmett

N. B.—Every item of information should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in such manner that it may be properly classified. Exact statement of OCCUPATION is required. See instructions on back of certificate.

THIS IS A PERMANENT RECORD. AGE should be stated EXACTLY, PHYSICIANS MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-12-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 6

County of Canyon — Primary Registration District No. 6 File No. 14104

City of Emmett (No. ..... St.) Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Akin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 5 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... ~~School boy~~
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank Akin

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Eliza Hitson

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Akin
(Address) Emmett Idaho

15. Filed 4/13 1916 J. L. Reynolds Local Registrar

SYRE - YORK CO., PTRS. & SONS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 3 1916, to Apr 8 1916, that I last saw h— alive on Apr 8 1916, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Meningitis

(Duration) 5 Yrs. ..... mos. 5 ds.

Contributory (Secondary) Bronchitis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Reynolds M. D.

4/13 1916 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Cem. DATE OF BURIAL: 4/9 1916

20. UNDERTAKER: Emmett Idy ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated in full. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14132

Registered No. .....

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

County of Gem

City of Emmett (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Washington Sherard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. (Month) Aug (Day) 17 1846 (Year)

7. AGE: 69 Yrs. 8 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Maysville. Mo.

10. NAME OF FATHER Dont know

11. BIRTHPLACE OF FATHER (State or Country) Dont know

12. MAIDEN NAME OF MOTHER Dont know

13. BIRTHPLACE OF MOTHER (State or Country) Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Bert Sherard
(Address) Emmett Ida

15.
Filed 4/13 1916 J. T. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
(Month) 4 (Day) 12 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1916, to Apr 12 1916, that I last saw h— alive on Apr 9 1916, and that death occured on the date stated above, at 11 30 P M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
.....
.....
(Duration) Years Yrs. ..... mos. ..... ds.
Contributory (Secondary) Rheumatism
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. T. Reynolds M. D.
4/13 1916 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 4/14 1916

20. UNDERTAKER: C. A. Buckman
ADDRESS: Emmett

Every item of information should be carefully supplied. AGE should be classified. EXACT statement of CAUSE OF DEATH in plain terms, so that it may be properly classified, should state CAUSE OF OCCUPATION is very important. See instructions on back of certificate.

BYRNE - YORK CO., PTRS. & BOOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada — Registration District No. 124 — File No. 14133

City of Kuna — Primary Registration District No. 1004 — Registered No. 93

(No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Dillon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. March (Month) 27 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... ✓

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kuna Idaho

10. NAME OF FATHER L. S. Dillon

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Jessie E Gooding

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse E. Gooding

(Address) Gooding Idaho

15. Filed Apr 7 1916 — F L McCauley Local Registrar

E. J. Eaton

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 7th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 27 1916, to ..... 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Premature birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F L McCauley M. D.

4/7 1916 (Address) Kuna Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 10 days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Kuna Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Harris Hill Cemetery	4/8/1916
20. UNDERTAKER	**ADDRESS**
Schreiber & Sidenfaden	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BOOS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14134
Registered No. 105

1. PLACE OF DEATH.

County of Ada
City of Boise
(No. 320 State St.)

Registration District No. 2
Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald McG Bean

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write one word.): Married

6. DATE OF BIRTH.
March (Month) 16 (Day) 85 (Year)

7. AGE
62 Yrs. 1 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Scotland

10. NAME OF FATHER Donald McG Bean

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Jean McGillivray

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Sarah Hill
(Address) 1402 N. 11 St.

15.
Filed 4/30 1916
E. J. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h was alive on Oct 28 1915
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Locomotor Ataxia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... mos. ..... ds.
(Signed) W. B. Gerard M. D.
4/30 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/1 1916
20. UNDERTAKER: Schreiber & Sidenader — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & STNRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 14135

Registered No. 104

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 924 Fort St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catharine S. Pond

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. May (Month) 26 (Day) 1837 (Year)

7. AGE: 78 Yrs. 11 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Peter Swineheart

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Eliza Cleftons

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hugh C. McElroy

(Address) Boise, Idaho

15. Filed April 29 1916

E. J. Eaton
Local Registrar

BYRNS - YORK CO., PTRS. & STRS. 24659

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) April 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 24 1916, to Apr 27 1916, that I last saw h[illegible] alive on Apr 27 1916, and that death occured on the date stated above, at 5 30 M.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Kolverson M. D.

19 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Apr 30 1916

20. UNDERTAKER: Frye Summers Co. — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 110 East Bannock St.)

File No. 14136
Registered No. 103
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Crowley.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
63 yrs. mos. ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Not obtainable

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER
(State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER
(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. N. Sandlap
(Address) Probate Judges - Boise

15. Filed 4/27 191 E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April 27 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1916, to April 27 1916 that I last saw h— alive on 27 April 1916 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) P. E. Shurz M. D.

19 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State Ada Co. Montana yrs ..... mos ..... days.
Where was disease contracted if not at place of death? 1st 1 year
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery Cather Plot	4/28 1916
20. UNDERTAKER Schreiber & Liebensperger	ADDRESS Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14137

Registered No. 102

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara Rockhill Brandt nee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March 1 (Month) (Day) (Year)

7. AGE: 33 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: W. M. Rockhill

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Cynthia Thurber

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. C. Brandt

(Address) Nampa Ida

15. Filed 4/25 1916

E. J. Cates
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24 1916, to April 25 1916, that I last saw h[illegible] alive on April 24 1916, and that death occured on the date stated above, at 1 O.P. M.

The CAUSE OF DEATH* was as follows:

Pericarditis, Septic, from Infected Appendix

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. 3 ds.

(Signed) L. P. McCallum M. D.

19.... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Nampa Ida

19. PLACE OF BURIAL OR REMOVAL: Spanish Fork Utah — DATE OF BURIAL: 4/25 1916

20. UNDERTAKER: Schreiber & Schenfeld — ADDRESS: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1004
(No. 410 State St.)

File No. 14138
Registered No. 97
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Doerr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Apr. 14 1916 / April 14 1916 (Month) (Day) (Year)

7. AGE: ___ yrs. ___ mos. ___ ds.
IF LESS than 1 day how many ... 3 hrs. or ... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho,

10. NAME OF FATHER: J. Geo. Doerr

11. BIRTHPLACE OF FATHER (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Maud J. Mueller

13. BIRTHPLACE OF MOTHER (State or Country): Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Doerr
(Address) Boise Idaho

15. Filed 4/17 1916 E. J. Carter Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 15 1916 / April 15 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 14 1916, to Apr. 15 1916 that I last saw him alive on Apr. 14 1916, and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth
(7 month)
(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) W. T. Tuxey M. D.
4/16 1916 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death?

Former or usual residence: Boise Idaho.

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 4/17 1916

20. UNDERTAKER: Schreiber & Siddenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5
Primary Registration District No. 1004
(No. 410 State St.)

File No. 14139
Registered No. 96
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Peroni

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	White	Single

6. DATE OF BIRTH: April 14 (Month) (Day) 1916 (Year)

7. AGE: ___ yrs. ___ mos. ___ ds.
IF LESS than 1 day how many ___ hrs. or 30 Minutes mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho.

10. NAME OF FATHER: Vincent Peroni

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Matilda Simpson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Vincent Peroni
(Address) Boise, Idaho

15. Filed 4/17 1916 E. J. Paton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 14 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ___ 191__, to ___ 191__, that I last saw h___ alive on ___ 191__, and that death occurred on the date stated above, at ___ M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (Secondary) ___ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) A. T. Lukens M. D.
4/16 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ days. In the State ___ yrs. ___ mos. ___ days.

Where was disease contracted if not at place of death?

Former or usual residence: Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 4/17 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14140

Registered No. 95

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 1004

County of Ada

City of Boise (No. 110, East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lee W. Chinnes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. March (Month) 28 (Day) 1868 (Year)

7. AGE: 48 Yrs. ... Mos. 11 ds.

IF LESS than 1 day how many ... hrs. ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Chin Gim Yuen

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: She Low

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Chinnes

(Address) Boise Idaho

15. Filed 4/13 1916 E. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 11½ (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 5 1916, to April 11½ 1916, that I last saw him alive on April 10½ 1916, and that death occured on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver and pancreas -

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) John Barker M. D.

4-11 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Cemetery — DATE OF BURIAL: April 15 1916

20. UNDERTAKER: Schreiber & Heidenfelder — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. W

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14141

Registered No. 94

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 110, East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Hutchison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 63 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lebourer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A Schneider
(Address) Boise

15. Filed 4/11 1916. E. J. Catlin Local Registrar

SYMS - YORK CO., PTRS. & BKBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 1st 1916, to Apr 10 1916, that I last saw h..... alive on Apr 10 1916 and that death occured on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach
(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James J. Blunt M. D.
Apr 11 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pierce Town — DATE OF BURIAL: 4/12 1916

20. UNDERTAKER: Schneider & Hedenfeldt — ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14142

Registered No. 92

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No.

Primary Registration District No. 1004

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tankawa Ogawa

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept 24 (Month) 24 (Day) 1890 (Year)

7. AGE: 25 Yrs. 6 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Sheepherder

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Japan

10. NAME OF FATHER Saisaku Ogawa

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. T. Graham

(Address) Boise Idaho

15. Filed 4/6 1916 E. J. Cutts Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4th 1916, to April 5 1916, that I last saw h[illegible] alive on April 5 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Burned to crush on legs, bad shock, etc. with Pneumonia and Exhaustion

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. P. McCalla M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence ..... Sheepwagon

19. PLACE OF BURIAL OR REMOVAL: Yokohama Japan | DATE OF [illegible]: April 12 1916

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS-[illegible] CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14143

Registered No. 91

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 142 E Grove St.)

Registration District No. 4

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Edward Ness

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. September 2 (Month) (Day) 1884 (Year)

7. AGE: 31 Yrs. 7 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Electrician

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER John Ness.

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances M Ness

(Address) 1411 Eastman

15. Filed 4/7 1916

E. X. Cater
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 5 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ April 6 1916, to ~~1916~~, that I last saw him alive on April 7 1916, and that death occured on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Accidently Electrocuted

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner M. D.

4/6 1916 (Address) Boise Idaho Ada County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 4/9 1916

20. UNDERTAKER: Schreiber & Liedtke — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14144

Registered No. 90

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 1407 Grove St.)

Registration District No. [illegible]

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Theophilus W. Randall

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. February 15th 1834 (Month) (Day) (Year)

7. AGE: 82 Yrs. 1 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Surveyor

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 18 yrs.

9. BIRTHPLACE (State or Country): Bath, England

10. NAME OF FATHER: William Randall

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. T. W. Randall

(Address) 1407 Grove St., Boise, Idaho

15. Filed 4/7 1916

R. J. Cator
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 6 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 1916, to April 6 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo Calvert M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 4/9 1916

20. UNDERTAKER: Schreiber & Redemp — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1445

Registered No. 87

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City or Boise

(No. 1308 Franklin St.)

If death occurs away from usual residence, give facts required for under special information.

2. FULL NAME Mrs Lutitia Swartz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Oct (Month) 11 (Day) 1839 (Year)

7. AGE: 76 Yrs. 5 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Thomas Caldwell

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Catherine Fullerton

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary B Summers

(Address) Boise Idaho

15. Filed 4/8 1916 E. F. Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 7 1916, to Apr 7 1916, that I last saw h[illegible] alive on Apr 7 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno R Summers M. D.

4/7 1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: W Eisen Idaho. DATE OF BURIAL: Apr 9 1916

20. UNDERTAKER: Jay V Summers ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1416

Registered No. 87

1. PLACE OF DEATH.

County of Boise

City of Idan

(No. 440, State St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tom Sing

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 68 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): a a

12. MAIDEN NAME OF MOTHER: a a

13. BIRTHPLACE OF MOTHER (State or Country): a e

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. L. Adams

(Address) Boise, Ida

15. Filed 4/5 1916

E. [illegible]
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1916 to April 4 1916, that I last saw h alive on April 4 1916, and that death occured on the date stated above, at 9 20 P.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Paralysis, Right side

(Duration ..... yrs. ..... mos. 4 ds.

(Signed) W. T. Hallman M. D.

4/5 1916 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: China Cemetery — DATE OF BURIAL: 4/6 1916

20. UNDERTAKER: Schreiber & Liedenfeldt — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. ....

Primary Registration District No. 1004

(No. 1216 N. 9 St. St.)

File No. 14147

Registered No. 86

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank O Judkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 8 (Day) 1852 (Year)

7. AGE 63 Yrs. 4 Mos. 24 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): ....

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Florence Judkins

(Address) 1216 No 9 St Boise Idaho

15. Filed 4/7 1916 — E. J. Eaton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1916, to April 2 1916, that I last saw him alive on April 2 1916, and that death occured on the date stated above, at .... M.

The CAUSE OF DEATH* was as follows:

Brights disease

(Duration) 2 Yrs. .... mos. .... ds.

Contributory (Secondary) ....

(Duration .... yrs. .... mos. .... ds.

(Signed) R. E. Hurtz M. D.

19.... (Address) ....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? ....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 4/3 1916

20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

Holverson.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1007

File No. 14148

Registered No. 85

1. PLACE OF DEATH.

County of Ada.

City of Boise.

(No. 2614 Madison St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carrie Imel.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married

6. DATE OF BIRTH. Oct (Month) 26. (Day) 1 (Year)

7. AGE: 64 Yrs. 5 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not of the United States

10. NAME OF FATHER: William West.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Baldwin.

13. BIRTHPLACE OF MOTHER (State or Country): Not of the United States.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Don E. Imel

(Address)

15. Filed 4/N 1916 E. J. Cate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 23 1916, to Apr. 1 1916, that I last saw h er alive on Apr. 1 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Uraemia, F. Bright's
(Treated by a Chiropractor until convulsion started)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Gastric Influenza

(Duration ..... yrs. 3 mos. ..... ds.

(Signed) H. M. Holverson M. D.

19..... (Address) 317 Empire

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fort Sumner — DATE OF BURIAL: Apr 3 1916

20. UNDERTAKER: Morris Hill Cem — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24852

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 14149
Registered No. 83

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 410, Hale St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Poston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Feb. (Month) 2d (Day) 1860 (Year)

7. AGE: 56 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Va

10. NAME OF FATHER: no obtainable

11. BIRTHPLACE OF FATHER (State or Country): " a

12. MAIDEN NAME OF MOTHER: a a

13. BIRTHPLACE OF MOTHER (State or Country): a a

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. L. Poston
(Address) Placerville Ida

15. Filed [illegible] 191[illegible] E. L. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1916, to May 30 1916, that I last saw h[illegible] alive on May 30 1916 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma (Superior Maxilla)

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred A Tellingly M. D.

3/31 1916 (Address) Lake Side

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 4/2 1916

20. UNDERTAKER: Schreiber & Lieberman | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

A7

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14150

Registered No. 24

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2064

(No. 31st & Madison St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doris Elaine Titmus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan 2nd (Month) (Day) 1916 (Year)

7. AGE ——— Yrs. 3 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Boise, Idaho.

10. NAME OF FATHER J. L. Titmus

11. BIRTHPLACE OF FATHER (State or Country) Colorado

12. MAIDEN NAME OF MOTHER Gladys Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNO

(Informant) J. L. Titmus

(Address) Owyhee Ada Co.

15.

Filed April 22 1916 E. J. Hart Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191...,

that I last saw h... alive on ——— 191...,

and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Suffocation

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

.....(Duration ——— yrs. ——— mos. ..... ds.

(Signed) R. E. Sturtz M. D.

... (Address) Boise

...e the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) ... INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

...ENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

...t place ...f death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Ada Co. Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 4/22 1916

20. UNDERTAKER: Schreiber & Siedenfaden | ADDRESS: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

13529

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 14151
Registered No. 19

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. Soldiers Home St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Caleb B. Sharp

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1843 (Year)

7. AGE: 73 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: not obtainable

11. BIRTHPLACE OF FATHER (State or Country): not obtainable

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. G. Burnett
(Address) Soldiers Home

15. Filed 4/1 1916 E. F. Eaton Local Registrar

SYMS - YORK CO., PTRS. & BKBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2 1916, to March 31 1916, that I last saw him alive on March 29 1916, and that death occured on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Anemia (Pernicious)

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred A. Wengatt M. D.
3/31 1916 (Address) Taft Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE. (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: April 1 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14152

Registered No. 20

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

County of Ada

City of Boise,

(No. Idaho State Prison)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dan Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 19 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Paroled Convict
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jackson Miss.

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. W. McKay
(Address) Boise

15. Filed 4/8 1916 E. H. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 4th (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1916, to April 4 1916, that I last saw h alive on 191, and that death occured on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Tuberculosis meningitis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) W. Calluck M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prison Cemetery — DATE OF BURIAL: 4/8 1916

20. UNDERTAKER: Schreiber & Anderson — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14153

Registered No. 21

1. PLACE OF DEATH.

County of Ada

City of Near Boise

(No. ~~street~~ Boise City ~~Ward~~)

Registration District No. 8

Primary Registration District No. 2004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Green Adams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. September 26, 1847 (Month) (Day) (Year)

7. AGE: 68 Yrs. 6 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: retired mine owner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Darwin, Clark Co, Illinois

10. NAME OF FATHER: Abner Adams

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Mary Rhodes

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Russell G. Adams

(Address) Silver City, Idaho

15. Filed 4/8 1916

E. J. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1916, to 4-7 1916, that I last saw h~~im~~ alive on 4-1 1916, and that death occured on the date stated above, at 2a. M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Myocarditis

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) W. M. Fallenman M. D.

4/8 1916 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 4/9 1916

20. UNDERTAKER: Schreiber & Sidenman — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. NO. 6-25 M. 1-15-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 8 — Primary Registration District No. 2004 — Registered No. 1154

County of Ada

City of Meat Boise (No. 1915 Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John M Hoover

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (write the word): Married

6. DATE OF BIRTH. June (Month) 27 (Day) 1842 (Year)

7. AGE: 73 Yrs. 7 Mos. 11 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION (a) Trade, profession or particular kind of work: Farmer (b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Hoover

11. BIRTHPLACE OF FATHER (State or Country): Not Obtained

12. MAIDEN NAME OF MOTHER: Jane Caldwell

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence M Hoover

(Address) R.F.D. 2 Boise Idaho

15. Filed ..... 19 16 — [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/5 1916, to 4/9 1916, that I last saw h[illegible] alive on 4/9 1916, and that death occured on the date stated above, at 9:45 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred Addleman M D

4/10 1916 (Address) Salt Lake

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL

Pierce, Idaho Saturday April 15 1916

20. UNDERTAKER — ADDRESS

Simpson Undertaking Co

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully considered. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

Boise.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 14155
Registered No. 23

1. PLACE OF DEATH.
County of Ada
City of Ustick,
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mattie L. Smith.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 15 (Day) 1884 (Year)

7. AGE: 31 Yrs. 11 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado.

10. NAME OF FATHER: Elder Leppert.

11. BIRTHPLACE OF FATHER (State or Country): Arkansas.

12. MAIDEN NAME OF MOTHER: Jane Elkin.

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arthur H. Smith.
(Address) Ustick

15.
Filed April 17th, 1916
E. F. Heath
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1916, to Apr 16 1916, that I last saw h[illegible] alive on Apr 16 1916, and that death occured on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart.

(Duration) 10 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) 2 yrs. — mos. — ds.

(Signed) R. L. Glasscock M. D.

4/17 1916. (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. | DATE OF BURIAL: Apr 17 1916

20. UNDERTAKER: Fry & Summers. | ADDRESS: Boise Idg.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of

(No. Ven Bonne St.)

Registration District No. 8

Primary Registration District No. 2004

File No. 14156

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Olivia Aldeva

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: 23 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Eustaquio Arguinchona

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Lucia Loheaga

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) Mrs Jaurido

15. Filed April 24th, 1916

E. H. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 24 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ saw April 25 1916, to 1916, that I last saw h[illegible] alive on and April 24 1916 and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Accidental Electrocution in Main Yard Canal

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Clyde E. Hammond M. D.

4/25 1916 (Address) Twin Falls Ida County

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 4/26 1916

20. UNDERTAKER: Schreiber & Sidenstrom — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BKBS. 24653

Bo Treasur.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 14157
Registered No. 26

1. PLACE OF DEATH.
County of Ada
City of Nat Boise (No. On, Bench, Nay Boise St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary, E, Digger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: Aug. (Month) 17 (Day) 1833 (Year)

7. AGE: 82 yrs. 8 mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housework
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio,

10. NAME OF FATHER John Bowen

11. BIRTHPLACE OF FATHER (State or Country) Delaware

12. MAIDEN NAME OF MOTHER Elizabeth Canfield

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs R. Sergeant
(Address) Boise R#2

15. Filed Apr 30 1916 E. H. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1916, to April 28 1916, that I last saw her alive on April 28 1916 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Old age with Myocarditis
Senility

(Duration) yrs. 3 mos. ds.

Contributory (Secondary) .....
(Duration) yrs. mos. ds.

(Signed) Carrie C. Freeman M. D.
4/29 1916 (Address) 220 Idaho Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: April 30 1916

20. UNDERTAKER: Fry & Summers | ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 7006

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14163

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Nampa

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hellen Evelen Huntley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Jan 28 (Month) (Day) 1916 (Year)

7. AGE: .....Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nampa Ida

10. NAME OF FATHER: William A Huntley

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Lizzie Baden

13. BIRTHPLACE OF MOTHER (State or Country): Nevada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Baden

(Address) Nampa Idaho

15. Filed April 1 1916 W. D. Calonge Local Registrar

By ..... Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 29 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 26 1916, to Mar 29 1916, that I last saw her alive on Mar 29 1916, and that death occured on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:

Influenza

.....(Duration) .....Yrs. .....mos. 6 .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) J. H. Murray M. D.

4/7 1916 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlenlaun — DATE OF BURIAL: April 2 1916

20. UNDERTAKER: F. R. Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

8-7158

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 14165
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob B Wolfe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 29 (Day) 1847 (Year)

7. AGE 68 Yrs. 4 Mos. 7 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs H. E. Allen
(Address) Nampa Ida R.D.

15. Filed May 6 1916 Dr D Coburge Local Registrar
Nampa Canfield Deputy.

SYMS - YORK CO. TYPE & PRINT LEADER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 5th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/14 1916, to 5/5 1916, that I last saw him alive on 5/4 1916, and that death occured on the date stated above, at 7-20 A.M.

The CAUSE OF DEATH* was as follows:

Hepatic cirrhosis
ataxy
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Lobar pneumonia
(Duration ..... yrs. ..... mos. 5 ds.

(Signed) H E Robinson M. D.
5/6 1916. (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem. DATE OF BURIAL: 5/6 1916

20. UNDERTAKER: H K Robinson ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 7

Primary Registration District No. 1006.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14166

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Nampa

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Winnie P. Haggett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 22 (Day) 1887 (Year)

7. AGE: 28 Yrs. 9 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kas.

10. NAME OF FATHER: J. M. Largent

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Effie Soucier

13. BIRTHPLACE OF MOTHER (State or Country): Kas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Russell Largent

(Address) Nampa Ida

15. Filed May 8 1916 Verda Young Local Registrar

Emma Hatfield Deputy

SYMS - YORK CO., PTD. 6 MOS. 14688

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1916, to May 6 1916, that I last saw h[illegible] alive on May 6 1916, and that death occured on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

Eleven Days following

Miscarriage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Endocrocites

(Duration) Few yrs. about mos. ..... ds.

(Signed) W. R. Meredith M. D.

5/8 1916 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sherlaine — DATE OF BURIAL: 5/8 1916

20. UNDERTAKER: F. K. Robinson — ADDRESS: Nampa Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14167

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 2006

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Monika Winter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 25 (Day) 1859 (Year)

7. AGE: 57 Yrs. 3 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Christ Hagner

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Winter

(Address) .....

15. Filed April 27 1916 Ord O Calvage Local Registrar

By ..... Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22 1916, to April 26 1916, that I last saw her alive on April 25 1916, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency &
Myocardial Insufficiency

(Duration) Several yrs. years mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. Clyde Watson M. D.

4/27 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Catholic Cemetery

DATE OF BURIAL: 4-28 1916

20. UNDERTAKER: Fred K Robinson

ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14168

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of .....

(No. ....., ... St.)

Registration District No. .....

Primary Registration District No. 2006

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Braden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 27 (Day) 1858 (Year)

7. AGE: 57 Yrs. 6 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Wis

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Melville Braden

(Address) Nampa Ida

15. Filed April 24 1916 Mark D. Calvert Local Registrar

By Anna Kupferschmidt, Deputy.

SYMS - YORK CO., PTRS. & STNR. 24252

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1915, to Apr 19 1916, that I last saw him alive on Apr 19 1916, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(No T.B in Sputum)

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs ..... mos. ..... ds.

(Signed) H. P. Ross M. D.

Apr 24 1916 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 4-25 1916

20. UNDERTAKER: Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH 7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14169

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. 6

(No. ....., ... St.)

2. FULL NAME Frank M Ruse Sr.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 13 (Day) 1854 (Year)

7. AGE: 62 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Lynchburg Ohio

10. NAME OF FATHER: A H. Ruse.

11. BIRTHPLACE OF FATHER (State or Country): Do not Know

12. MAIDEN NAME OF MOTHER: Louisa

13. BIRTHPLACE OF MOTHER (State or Country): Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. D. Heithecker
(Address) Nampa Idaho

15. Filed April 11 1916 D. S. Calvert Local Registrar
By ..... Assistant Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend him 191..., that I last saw him alive on ..... and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Asked to see him Died of heart failure

(Duration) ✓ Yrs. ✓ mos. ✓ ds.

Contributory (Secondary) ✓

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Smith M. D.

4/10, 1916 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlenbarn Cem

DATE OF BURIAL: 4/12 1916

20. UNDERTAKER: Fred Robinson

ADDRESS: Nampa

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of .....

(No. ....., ... St.)

Registration District No. 7

Primary Registration District No. 2006

File No. 14170

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eliza Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Sep (Month) 6 (Day) 1 (Year)

7. AGE: 84 Yrs. 7 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Joshua Davis

11. BIRTHPLACE OF FATHER (State or Country) Dont know

12. MAIDEN NAME OF MOTHER Jane Glasgow ~~Jane Glasgow~~

13. BIRTHPLACE OF MOTHER (State or Country) Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Rinker

(Address) .....

15. Filed April 17 1916 Dr D Maloney Local Registrar

by Warfield Deputy.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12 1916, to April 16 1916, that I last saw her alive on April 12 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Chronic Poisoning

(Duration) ..... Yrs. ..... mos. 7 ..... ds.

Contributory (Secondary) Chronic Brights long time

(Duration 8 yrs. ..... mos. ..... ds.

(Signed) D H Murray M. D.

4/17 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Valley Cem — DATE OF BURIAL: 5/17 1916

20. UNDERTAKER: Fred Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 14171
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roby Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 11 (Day) 1897 (Year)

7. AGE: 19 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouria

10. NAME OF FATHER: W. J. Powell

11. BIRTHPLACE OF FATHER (State or Country): Dont know

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. G. Miller
(Address) Caldwell Idaho Rout 4

15. Filed April 12 1916 Dr D Galong Local Registrar
Visum Caldwell Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1916, to April 11 1916, that I last saw h.. alive on March 29 1916, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Acute

(Duration) Yrs. 5 mos. ..... ds.

Contributory (Secondary) .....

(Duration) — yrs. — mos. — ds.

(Signed) H. G. Miller M. D.

4-12 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohler Lawan Tampa — DATE OF BURIAL: 4/12 1916

20. UNDERTAKER: W. C. Dyer — ADDRESS: Caldwell Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 1006
(No. ..... St.)

File No. 14172
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orville Cary Frazer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Mar (Month) 9 (Day) 1899 (Year)

7. AGE: 17 Yrs. 1 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J O Frazer

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Jennie Hall

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J O Frazer
(Address) Boise

15. Filed April 11 1916 Dr J D Calonge Local Registrar
Deputy.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/5 1916, to 4/9 1916, that I last saw him alive on 4/9 1916, and that death occured on the date stated above, at 2-55 A.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of the lungs
Acute

(Duration) Yrs. 9 mos. ..... ds.
Contributory (Secondary): Influenza
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H L Robinson M. D.
4/11 1916 (Address) 317 4th St So Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem. DATE OF BURIAL: 4/11 1916

20. UNDERTAKER: Fred Robertson ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14173

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of .....

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 2006

2. FULL NAME Josh. George Burnie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	Married

6. DATE OF BIRTH.

Don't know (Month) ..... 1 (Day) ..... (Year)

7. AGE

51 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Nebraska

10. NAME OF FATHER George Burnie

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Jane Davis

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. O. Burnie

(Address) Nampa Ida

15. Filed April 19 1916 Ors D. Calonge Local Registrar

By Maxine Caldwell Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr (Month) 18 (Day) 16 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Clyde Watson M. D.

19... (Address) Local Health Off. Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn Cem.	4-19 1916
20. UNDERTAKER	**ADDRESS**
Fred Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Ida...
BOARD OF HEA...
Bureau of Vital St...

1. PLACE OF DEATH.
County of Cassia
City of Oakley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 170
Primary Registration District No. 2199
(No. ....., ... St.)

File No. 17 14
Registered No. 4
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hector Cobb Haight

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Aug 18 1869 (Month) (Day) (Year)

7. AGE: 46 yrs. 4 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Banker
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Hector D. Haight

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Louisa Leavitt

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): H. J. Nelson
(Address): Oakley, Idaho

15. Filed 3/25 1916 E. P. Graham Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... on March 23rd 1916, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac Failure (probably)
Instantly
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) H. J. Nelson M. D.
Mar 25 1916 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho
DATE OF BURIAL: 3/28 1916

20. UNDERTAKER: A. E. McBride
ADDRESS: Oakley Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. ; St.)

File No. 14175
Registered No. 8
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louisa C. Bailey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Widow

6. DATE OF BIRTH
Oct (Month) 20 (Day) 1838 (Year)

7. AGE
78 yrs. 6 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) N. Y.

10. NAME OF FATHER Robt Carrier

11. BIRTHPLACE OF FATHER (State or Country) Do not Know

12. MAIDEN NAME OF MOTHER Do not Know

13. BIRTHPLACE OF MOTHER (State or Country) Do not Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. R. Bailey
(Address)

15.
Filed April 17 191 6 Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1916, to April 16 1916, that I last saw her alive on April 15 1916, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) yrs. mos. 20 ds.
Contributory (Secondary) Indigestion
(Duration) yrs. mos. ds.

(Signed) Chas. B. Allen M. D.
4-17 1916 (Address) Parma Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Kuna Idaho
DATE OF BURIAL: 191

20. UNDERTAKER: Beckham Bros
ADDRESS: Parma Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 1976O

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14176

Registered No. 8

1. PLACE OF DEATH.

County of Canyon

City of ..... (If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 9

Primary Registration District No. 2007

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elsie Stradley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sep. (Month) 7 (Day) 1887 (Year)

7. AGE 7 9 Yrs. 6 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House Wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Lorenzo Dorriseman

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Celia Bolman

13. BIRTHPLACE OF MOTHER (State or Country) O.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret A Bradney

(Address) .....

15. Filed 4-5 1916 Ina Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 2 1916, to Apr. 5 1916, that I last saw h[illegible] alive on Apr. 4 1916, and that death occured on the date stated above, at 7:23 M.

The CAUSE OF DEATH* was as follows:

Apoplexy

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senile Debility

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Waldrop M. D.

4-5-1916 (Address) Parma Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Roswell — DATE OF BURIAL 4-5-1916

20. UNDERTAKER Peckham Case Co Parma — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24854

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14178

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Lyon
City of Juliaetta (No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benj Frank Moore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE Light
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married
6. DATE OF BIRTH Nov (Month) 24 (Day) 1844 (Year)
7. AGE 71 yrs. 4 mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country) Ohio
10. NAME OF FATHER Vincent Moore.
11. BIRTHPLACE OF FATHER (State or Country) Ohio.
12. MAIDEN NAME OF MOTHER Mary Moore.
13. BIRTHPLACE OF MOTHER (State or Country) Ohio
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Homer Cross.
(Address) Juliaetta Idaho.
15.
Filed April 17 1916 S. A. Roe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April (Month) 14 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 12, 1916, to April 14 1916
that I last saw him alive on April 14 1916
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Peritonitis
..... (Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) Probably Ulceration Stomach
..... (Duration) ..... yrs. 3 mos. ..... ds.
(Signed) S. A. Roe M. D.
April 15 1916 (Address) Juliaetta Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Juliaetta
DATE OF BURIAL April 17 1916

20. UNDERTAKER J. E. Croucher
ADDRESS Juliaetta

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Donnelly, Ida
May 9, 1916

Mr Falk,
Boise, Ida.

Dear Sir:

Enclosed please find death certificate, particulars will follow.

Yours truly,

Ruth McDonald
Registrar.
Donnelly,

Behind 14178

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14179
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Juliaetta
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christine Caroline Gumm Hofe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.
6. DATE OF BIRTH. April (Month) 28 (Day) 1857 (Year)
7. AGE: 58 Yrs. 10 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Germany
10. NAME OF FATHER: Heinrich Gumbong
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Katherine t—
13. BIRTHPLACE OF MOTHER (State or Country): Germany
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. Gumm Hofe
(Address) Juliaetta, Ida
15. Filed March 1916 S A Roe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from about May 1914, to March 11 1916, that I last saw h.. alive on March 11 1916, and that death occured on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Diabetic coma
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Diabetes mellitus
(Duration about 3 or 4 yrs. ..... mos. ..... ds.
(Signed) S A Roe M. D.
3/13 1916 (Address) Juliaetta, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Juliaetta, Ida — DATE OF BURIAL: Mar 13 1916
20. UNDERTAKER: J.C. Groseclose — ADDRESS: Juliaetta, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14180

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Juliaetta,

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Marshall Roe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.

6. DATE OF BIRTH. March 31 1849
(Month) (Day) (Year)

7. AGE: 66 Yrs. 10 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Minister
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kentucky.

10. NAME OF FATHER: Jas. Roe

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Louisa Templeman

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Sa Roe
(Address) Juliaetta

15. Filed Feby 22 1916 Sa Roe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby 20 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1915, to Feb 20 1916, that I last saw him alive on Feb 19 1916, and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Progressive paralysis

(Duration) 4 Yrs. mos. ds.

Contributory (Secondary) Arterio Sclerosis

(Duration 5 yrs. mos. ds.

(Signed) J. E. Hoyt M. D.

Feb 22nd 1916 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Juliaetta, Ida — DATE OF BURIAL: Feby 23 1916

20. UNDERTAKER: J. C. Hosedose — ADDRESS: Juliaetta, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14181

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

1. PLACE OF DEATH.

County of Latah

City of .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jennie M. Kite

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 29 (Day) 1852 (Year)

7. AGE: 63 Yrs. 5 Mos. 30 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Joseph Taylor.

11. BIRTHPLACE OF FATHER (State or Country): Penna

12. MAIDEN NAME OF MOTHER: Minerva Sproat

13. BIRTHPLACE OF MOTHER (State or Country): Penna

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. Kite.

(Address) Juliaetta Ida.

15. Filed Jany 30 1916. S. A. Roe Local Registrar

SVMS - YORK CO., PTRS. & BRDS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 21 1916, to Jany 28 1916, that I last saw h[illegible] alive on Jany 28 1916, and that death occured on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:

Uraemic poisoning

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Bright's Disease

(Duration about ½ yrs. ..... mos. ..... ds.

(Signed) S. A. Roe M. D.

1/30 1916 (Address) Juliaetta, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Juliaetta Ida — DATE OF BURIAL: Jany 31 1916

20. UNDERTAKER: [illegible] — ADDRESS: Juliaetta Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 66

Primary Registration District No. 7146

File No. 14182

Registered No. 4

County of

City of (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wilson Vance Hobbs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: (X) Aug (Month) 24 (Day) 1914 (Year)

7. AGE: 1 yrs. 8 mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Boyill Ida

10. NAME OF FATHER: D N Hobbs

11. BIRTHPLACE OF FATHER (State or Country): Maryland

12. MAIDEN NAME OF MOTHER: Nellie G. Ross

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D N Hobbs
(Address) Boyill Ida

15. Filed 5/25 1916 J L Shumpine Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/17 1916, to 4/24 1916, that I last saw him alive on 4/24 1916, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Infection Enteritis

(Duration) yrs. mos. 12 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. C. Gibson M. D.

4/24 1916 (Address) Boyill Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boyill Ida

DATE OF BURIAL: 5/25 1916

20. UNDERTAKER: J L Shumpine

ADDRESS: Boyill Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6
Primary Registration District No. 2146
File No. 14183
Registered No. 8

1. PLACE OF DEATH.
County of Latah
City of Boviill
If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bessie Hobbs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Girl	White	Single

6. DATE OF BIRTH
4 (Month) – 21 (Day) – 16 (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) None

9. BIRTHPLACE (State or Country) Boviill Ida

10. NAME OF FATHER Dudley Hobbs

11. BIRTHPLACE OF FATHER (State or Country) Maryland

12. MAIDEN NAME OF MOTHER Nellie G. Ross

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dudley Hobbs
(Address) Boviill Ida

15.
Filed 4/22 1916 J. L. Champion
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
4 (Month) – 21 (Day) – 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21 – 1916., to April 21 – 1916, that I last saw h[illegible] alive on April 21 – 1916, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. C. Gibson M. D.
4/21 1916 (Address) Boviill, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Boviill Ida	Apr 22 1916

20. UNDERTAKER	ADDRESS
J. L. Champion	Boviill Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14185
Registered No. 7

1. PLACE OF DEATH.
County of Latah
City of Genesee
(No. ....., ... St.)

Registration District No. 6
Primary Registration District No. 2142

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Miss Anna Miller

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH: January fifth 1842
(Month) (Day) (Year)

7. AGE: yrs. 74 mos. 3 ds. 24
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fridale, Norway

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lott H. Miller
(Address) Genesee Idaho

15.
Filed Apr. 27 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. 26 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 15 1916, to Apr 26 1916
that I last saw her alive on Apr 26 1916
and that death occurred on the date stated above, at 3:15 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

Duration: Over 1 year

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C J Tuomey M. D.
Apr 26 1916 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 4-28 1916

20. UNDERTAKER: J. E. Lambert
ADDRESS: Genesee Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

14186

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13

County of Boise

Primary Registration District No.

File No. 12

City of Lowerhorse Bend (No. ....., ... St.)

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Abraham woodfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: English

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 19 (Day) 1862 (Year)

7. AGE: 53 Yrs. 4 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Derbyshire Eng

10. NAME OF FATHER: Not knowing

11. BIRTHPLACE OF FATHER (State or Country): Not knowing

12. MAIDEN NAME OF MOTHER: Not knowing

13. BIRTHPLACE OF MOTHER (State or Country): Not knowing

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E Reed

(Address) Lowerhorse Bend

15.

Filed April 17 1915

E Vadney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw him alive on April 15 1916,

and that death occured on the date stated above, at X M.

The CAUSE OF DEATH* was as follows:

Abdominal

X (Duration) X Yrs. X mos. X ds.

Contributory (Secondary) X

X (Duration X yrs. X mos. X ds.

(Signed) X X M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Lowerhorse Bend

19. PLACE OF BURIAL OR REMOVAL: Lowerhorse Bend — DATE OF BURIAL: 4-18 1916

20. UNDERTAKER Rueff of Lowerhorse Bend — ADDRESS Lowerhorse Bend

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS & YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14187

Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gem

City of Maunture

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13

Primary Registration District No.

(No. ....., ... St.)

2. FULL NAME George W. Curry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Jan (Month) 1 (Day) 1837 (Year)

7. AGE: 81 Yrs. 3 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa

10. NAME OF FATHER: Nat Knauss

11. BIRTHPLACE OF FATHER (State or Country): Nat Knauss

12. MAIDEN NAME OF MOTHER: Nat Knauss

13. BIRTHPLACE OF MOTHER (State or Country): Nat Knauss

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. H. Slanker

(Address) Maunture

15.

Filed 4-10 1916

E Vadney
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1-14 1916, to April 7-16 1916, that I last saw him alive on April 7 1916, and that death occured on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:

Old Age and General Innate Causes

(Duration) 3 m 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E Vadney M. D.

4-10 1916. (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho

DATE OF BURIAL: 4-10-1916

20. UNDERTAKER: Loyd Coy

ADDRESS: Maunture

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 51
Primary Registration District No. 2130
File No. 3 14188
Registered No. 1

1. PLACE OF DEATH.
County of Canyon
City of Fruitland (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Stewart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: May (Month) 8 (Day) 1916 (Year)

7. AGE: — yrs. — mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. C. Stewart

11. BIRTHPLACE OF FATHER (State or Country): Neb

12. MAIDEN NAME OF MOTHER: Lillian Bates

13. BIRTHPLACE OF MOTHER (State or Country): Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J A Bates
(Address) Fruitland

15. Filed May 10 1916 Crispin Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 9th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-8-16 191, to 5-9-16 191, that I last saw her alive on 5-8-16 191, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Broncho Congenital Atelectasis
or Congenital Lack of development of Lungs
(Duration) 8 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Crispin Wright M. D.
5-9 1916 (Address) Fruitland, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
New Plymouth	May 9 1916

20. UNDERTAKER	ADDRESS
D. N. Adair	Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14189

Registered No. .....

1. PLACE OF DEATH.

County of Bonneville

City of Dessmet

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Bishop

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Indian	Single

6. DATE OF BIRTH. August 14 1915
(Month) (Day) (Year)

7. AGE — Yrs. 9 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Child none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Dessmet Coeur d'Alene Reser.

10. NAME OF FATHER Augustine Bishop

11. BIRTHPLACE OF FATHER (State or Country) Coeur d'Alene Reser.

12. MAIDEN NAME OF MOTHER Cecilia Moctmee

13. BIRTHPLACE OF MOTHER (State or Country) Coeur d'Alene Reser.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Louis Bishop

(Address) Desmet Idaho

15.

Filed April 29 1916 John Scott Asst. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 28th 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st 1916, to April 28th 1916, that I last saw him alive on April 28 1916, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(Duration) — Yrs. 4 mos. — ds.

Contributory (Secondary) .....

(Duration — yrs. — mos. — ds.

(Signed) Eugene F. Hoel M. D.

April 28 1916. (Address) Desmet Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mission Cemetery	April 30 1916
20. UNDERTAKER	ADDRESS
[illegible] Lost	Desmet Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24858

FORM V. S. No. 5-25 M. 1-16-13 No. 3

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14190

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 31

County of Benewah.

Primary Registration District No. .....

City of Desmet Idaho. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myrtle Violet Simons.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 15th (Day), 1879 (Year)

7. AGE: 38 Yrs. 11 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minnesota Ottertail Co.

10. NAME OF FATHER: Jacobus P Batdes.

11. BIRTHPLACE OF FATHER (State or Country): N.Y. State.

12. MAIDEN NAME OF MOTHER: Sophie De Rosier

13. BIRTHPLACE OF MOTHER (State or Country): N.Y. State.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ~~Simons~~ Simons.

(Address) Sanders Idaho.

15. Filed April 28 1916. John Peat Asst. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21 1916, to April 27th, 1916, that I last saw her alive on April 27th 1916, and that death occured on the date stated above, at 5.15 P.M.

The CAUSE OF DEATH* was as follows:

Appendicitis, Abscess and Sepsis.

(Duration) 0 Yrs. 0 mos. 9 ds.

Contributory (Secondary) Pregnancy.

(Duration 0 yrs. 3. mos. ..... ds.

(Signed) Dr. C.B. Cain M. D.

April 16 (Address) Tekoa Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos. 2 days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? Sanders, Idaho.

Former or usual residence Sanders, Idaho.

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Tekoa Washington.

DATE OF BURIAL: Apr. 29th

20. UNDERTAKER: Carl Schuterd

ADDRESS Tekoa, Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14191

Registered No. .....

Registration District No. 20

Primary Registration District No. 2012

1. PLACE OF DEATH.

County of Teton

City of Victor

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jess Sinclair

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 4 (Month) 15 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or 45 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Victor

10. NAME OF FATHER Jessie Sinclair

11. BIRTHPLACE OF FATHER (State or Country) Salt Lake Utah

12. MAIDEN NAME OF MOTHER Jennie Thorpe Sinclair

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jessie Sinclair

(Address) Victor Idaho

15. Filed 4-29 1916 G W Shaller Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-15 1916, to 4-28 1916, that I last saw h.r alive on 4-27 — 1916, and that death occured on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

.....

.....

.....(Duration) .....Yrs. ..... mos. 13 ds.

Contributory (Secondary) Congenital

.....(Duration .....yrs. .....mos. .....ds.

(Signed) Ben F. Roseman M. D.

4-29 1916 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL .....191.....

20. UNDERTAKER — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2075
File No. 14192
Registered No. [illegible]

1. PLACE OF DEATH.
County of Blaine
City of Carey.
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mr. George Berry.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 8. (Day) 1843 (Year)

7. AGE: 72 Yrs. 10 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bartie Co. Ohio

10. NAME OF FATHER: Dont Know.

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. George Berry
(Address) Carey Ida

15. Filed 4/25 1916 Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 21st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1916, to April 24 1916, that I last saw h[illegible] alive on April 1916, and that death occured on the date stated above, at 10:10 P M.

The CAUSE OF DEATH* was as follows:
Consumption

(Duration) 3 Yrs. X mos. X ds.
Contributory (Secondary): Hereditary
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Baugh M. D.
19..... (Address) Carey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? Loveland Colorado
Former or usual residence Carey Idaho 23 yrs.

19. PLACE OF BURIAL OR REMOVAL: Carey Cem. Cemetary — DATE OF BURIAL: 23 1916

20. UNDERTAKER: Hod Stone Neighbors — ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

6788 - YORK CO., PTRS. & ENGRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14193

Registered No.

1. PLACE OF DEATH.
County of Lewis
City of Winchester (No. ....., ... St.)

Registration District No. 48
Primary Registration District No. 2127

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Garret Sullivan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: August 17 (Month) (Day) 1865 (Year)

7. AGE: 50 yrs. 8 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Freedom Wise

10. NAME OF FATHER: Humphrey Sullivan

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Winnified O'Gara

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs H. A. Graham
(Address) Winchester

15.
Filed 4-20-1916 Elbert H. Rogers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 20th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 - 1915, to April 20th 1916
that I last saw him alive on April 17th 1916
and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (Duration) 10 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elbert H. Rogers M. D.
4-20 - 1916 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Golden Ridge Cemetery — DATE OF BURIAL: 4-21-1916

20. UNDERTAKER: H R Merchant — ADDRESS: Clarkston Wash

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2176

Primary Registration District No. 98

File No. 14194

County of Lorenzo

City of Lorenzo (No. ....., St.)

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clinton Homer Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	

6. DATE OF BIRTH: Feb (Month) 5 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Annis.

10. NAME OF FATHER: Clinton V. Williams

11. BIRTHPLACE OF FATHER (State or Country): dont know.

12. MAIDEN NAME OF MOTHER: Hazel Rainey

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy Rainey.
(Address) Lorenzo R D # 1

15. Filed 4-29 1916. Ray H. Fisher, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-5 1916, to Feb 26 1916, that I last saw him alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature 7 mo.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray H. Fisher M. D.

2-27 1916. (Address) Rigby, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Annis. DATE OF BURIAL: 2-28 1916

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14195

Registration District 2176
Primary Registration District No. 98
(No. ....., ... St.)
Registered No. 11
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Jefferson
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elva Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb 17 (Month) (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 42 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or dstablishment in which employed (or employer) Infant

9. BIRTHPLACE (State or Country): Rigby Ida

10. NAME OF FATHER: Kenney Johnson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Barbara Kyle

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Kenney Johnson
(Address) .....

15. Filed Apr 28 1916 Capt Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1916 to Apr 4 1916, that I last saw her alive on Apr 4 1916, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:
Marasmus

(Duration) 1 yrs. mos. 42 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Anderson M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby Idaho
DATE OF BURIAL: Apr 6 1916
20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTGS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 216
Primary Registration District No. 98
(No. ....., ... St.)

File No. 14196
Registered No. 15
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Infant

6. DATE OF BIRTH: Dec 30 (Month) 1915 (Day) (Year)

7. AGE: ..... yrs. ..... mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant –
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Lorenzo R D 1 –

10. NAME OF FATHER: John Ellis –

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake City Utah –

12. MAIDEN NAME OF MOTHER: Laura Call –

13. BIRTHPLACE OF MOTHER (State or Country): Willard Utah –

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Ellis
(Address) .....

15. Filed 4-29-16 191.... Ray N. Fisher, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 7th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1915, to Jan 7 1916 that I last saw h.m alive on Jan 7th 1915, and that death occurred on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:
Infant – Probably – Congenital obstruction
..... (Duration) ..... yrs. ..... mos. 8 ds.
Contributory (Secondary) none
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A Anderson M. D.
1-17 1916 (Address) Ruby Idaho –

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Little Butte Cem. DATE OF BURIAL: Jan 9 1916.

20. UNDERTAKER ..... ADDRESS .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 216
Primary Registration District No. 98
(No. ..... St.)

File No. 14197
Registered No. 14
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH Apr 13 1916
(Month) (Day) (Year)

7. AGE ..... yrs. ..... mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rigby, Idaho

10. NAME OF FATHER Albert Johnson

11. BIRTHPLACE OF FATHER (State or Country) Salt Lake City Utah

12. MAIDEN NAME OF MOTHER Christine Adamson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Johnson
(Address) .....

15. Filed 4-29 1916. Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Apr 13th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 13 1916, to Apr 15 1916 that I last saw him alive on Apr 15 1916, and that death occurred on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:
Hemorrhage
Intestinal Stasis

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. A. Anderson M. D.
Apr 15 1916 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rigby Ida.	Apr 16 1916

20. UNDERTAKER ..... ADDRESS .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Adams
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2176
Primary Registration District No. 98
(No. ....., ... St.)

File No. 14199
Registered No. 72
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josiah Scott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Married

6. DATE OF BIRTH
Aug (Month) 20 (Day) 1874 (Year)

7. AGE
67 yrs. 5 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER John Scott

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Elizabeth Mcnary

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John R. Scott
(Address) Cambridge - R.F.D. #1

15.
Filed 4-29 1916. Ray N. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on Feb 10 1916,
and that death occurred on the date stated above, at 1:30 P.M.
The CAUSE OF DEATH* was as follows:
Tumor.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ames	2/13 1916

20. UNDERTAKER	ADDRESS
J. Kyong	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 2176

County of Jefferson

Primary Registration District No. 98

City of Rigby

(No. ....., ... St.)

File No. 14200

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alma Marmi Robertson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, ~~MARRIED~~, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH: Feb (Month) 18 (Day) 1880 (Year)

7. AGE: 36 yrs. 1 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas Robertson

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Clarice D'Grue

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. L. Call M.D.
(Address) Rigby Idaho

15. Filed April 29 1916. Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1914, to Apr 1916, that I last saw him alive on Aug 1915, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R H Fisher M. D.

April 8 1916 (Address) Rigby Ida

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 6 mos. ..... days. In the State 5 yrs. 3 mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence Rigby Idaho

19. PLACE OF BURIAL OR REMOVAL: Rigby | DATE OF BURIAL ..... 191...

20. UNDERTAKER: A Hatch. | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 21

Primary Registration District No. 2022

(No. .... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14202

Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Blaine

City of Hailey

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary A. Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. June (Month) 19 (Day) 1864 (Year)

7. AGE: 51 Yrs. 10 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Chas Peterson

11. BIRTHPLACE OF FATHER (State or Country): ←

12. MAIDEN NAME OF MOTHER: ←

13. BIRTHPLACE OF MOTHER (State or Country): ←

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Rodney Brown
(Address) Rock Creek, Ida

15. Filed May 7 1916. Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1916, to May 3 1916, that I last saw her alive on May 3 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Carcinoma of breast
(Duration) dont know Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) J. G. Paoff M. D.
19 (Address) Hailey Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida — DATE OF BURIAL: May 5 1916

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14203

Registered No. .....

Registration District No. 21

Primary Registration District No. 2075

(No. ..... St.)

1. PLACE OF DEATH.

County of Blaine

City of Carey

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Aitken

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mail

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. October (Month) 25 (Day) 1846 (Year)

7. AGE: 64 Yrs. 6 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: James Aitken

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Aitken

(Address) Carey Idaho

15. Filed June 1 1916 Robert H Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21st 1916, to May 21st 1916, that I last saw h[illegible] alive on May 21st 1916 and that death occured on the date stated above, at about 8 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Left Lung

I understand about

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. J. Allen M. D.

19..... (Address) Bellevue Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Carey Ida — DATE OF BURIAL: May 22 1916

20. UNDERTAKER: Friends — ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14204

Registered No. 9

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. ....., ... St.)

Registration District No. 127

Primary Registration District No. 2200

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Cohen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Don't Know (Month) 1 (Day) (Year)

7. AGE: 62 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Louisiana

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 5/8 1916 — N C Mowery, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1910, to 1916
that I last saw him alive on May 3 1916
and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(Duration) ..... yrs. mos. 2 ds.
Contributory (Secondary) Epilepsy & arteriosclerosis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) N C Mowery M. D.
5/6 1916 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Drummond Cemetery
DATE OF BURIAL: 5-7-16 1916

20. UNDERTAKER: R G Rastell, Wallace Idaho
ADDRESS

By Baird

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2200
File No. 14205
Registered No. 16

1. PLACE OF DEATH.
County of Shoshone
City of Avery (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. Kitayama.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: Japness

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Do not know.

6. DATE OF BIRTH. Do not know (Month) (Day) (Year)

7. AGE: about Yrs. 52 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sea faber.
(b) General nature of industry, business, or establishment in which employed (or employer): Japan

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER: Do not know

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R C Cannon.
(Address) Avery Ida.

15. Filed May 14 1916. J. H. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 10a.M.
The CAUSE OF DEATH* was as follows:
Crushed by switch engine on Milwaukee Ry
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. R. Mayer Coroner
May 16 1916 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Missoula — DATE OF BURIAL: May 16 1916

20. UNDERTAKER: V. E. Stamp — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14206

Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Mace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 122

Primary Registration District No. 220 D

(No. Mace Idaho St.)

2. FULL NAME William Nance

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH.

(Month) (Day) 1 (Year)

7. AGE

50 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... miner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) North Carolina

10. NAME OF FATHER Ben Nance

11. BIRTHPLACE OF FATHER

(State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Vicey Anderson

13. BIRTHPLACE OF MOTHER

(State or Country) North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mitchell Nance

(Address) Mace Ida

15.

Filed 5/24 1916 J. H. Mowry Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on .....,

and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Struck by O&W Ry. Extra

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....

(Duration) ... Yrs. ... mos. ... ds.

(Signed) Chas R Mowry M. D.

May 22 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?.....

Former or usual residence Mace Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Freman Nash	May 23 1916

20. UNDERTAKER	ADDRESS
Nash Undr Co	Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 2200
File No. 14207
Registered No. 12

1. PLACE OF DEATH.
County of Shoshone
City of Black Bear (No. Black Bear St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alma Gill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 8 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Michael Gill

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Eliza Gibbons

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Ursuie Gill
(Address): Black Bear

15. Filed 5/29 1916 W. D. Mowry Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 , to 191 , that I last saw her alive on May 27 1916, and that death occured on the date stated above, at 8 25 M.

The CAUSE OF DEATH* was as follows: Fracture of skull base to falling in creek drowned

(Duration) Instant

Contributory (Secondary) None

(Duration yrs. mos. ds.

(Signed) W. D. Mowry M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs mos days. In the State yrs mos days
Where was disease contracted if not at place of death?
Former or usual residence: Black Bear

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: May 30 1916

20. UNDERTAKER: Ward Mtd Co ADDRESS: Wallace Ida

County of Lewiston
City of NezPerse
Registration District No. 49
Primary Registration District No. 2128
(No. Hospital St.)

BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
File No. 14208
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada May Whitney

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced. (Write the Word): Single

6. DATE OF BIRTH. May (Month) 1 (Day) 1904 (Year)

7. AGE. 12 Yrs. Mos. 15 ds.
IF LESS than 1 day, how many.....hrs. or .....min.?

8. OCCUPATION.
(a) Trade, profession or partcular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE. (State or Country) Washington

10. NAME OF FATHER: A.R.Whitney

11. BIRTHPLACE OF FATHER (State or Country) Minn.

12. MAIDEN NAME OF MOTHER: Alice Donica

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A.R.Whitney
(Address) Kamiah Idaho

15. Filed 5/17 1916 W.T. McMahan Local Registrar.

Place Where Remains are to be Sent. Kamiah Idaho
Date of Shipment May 16 1916
SHIPPING UNDERTAKER C.J.Vassar
ADDRESS Lewiston Idaho Firm Name

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4 1916, to May 16 1916; that I last saw h alive on May 16 1916, and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH was as follows:
Pleuritis

(Duration) Years 1 mos. 13 ds.
Contributory (Secondary) Appendicitis
(Duration) Years mos. ds.

(Signed) John H Allen M. D.
May 17 1916 (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Sucidial or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)
At place St Joseph Hospital in the
of death yrs. mos. days State yrs. 1 mos. 12 days

Where was disease contracted if not at place of death
Former or usual residence Kamiah

19. PLACE OF BURIAL OR REMOVAL Kamiah Cemt Date of Burial 5/17 1916

20. UNDERTAKER C. J. Johnson Address Kamiah Ida

The information on this certificate is an exact COPY of the official certificate filed at place of death.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 78
County of Bonner Primary Registration District No. 2135
City of ..... (No. ....., ... St.)

File No. 14209
Registered No. 870

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jefferson Murphy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White.	

6. DATE OF BIRTH: Nov 1 (Month) (Day) 1914 (Year)

7. AGE: ..... yrs. 1 7 mos. ..... ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bonner Co.

10. NAME OF FATHER Charles Murphy

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Sulla Williams.

13. BIRTHPLACE OF MOTHER (State or Country) Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. C. Jenkins
(Address) Dalby, Idaho.

15. Filed May 23 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1916, to ..... 191..
that I last saw him alive on May 10 1916
and that death occurred on the date stated above, at 10 M.
The CAUSE OF DEATH* was as follows:

Pneumonia Croupous.

..... (Duration) ..... yrs. ..... mos. 16 ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. H. Williams M. D.
May 13 1916. (Address) Sand Point Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sand Point — DATE OF BURIAL: May 14 1916

20. UNDERTAKER: Bonner — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SPACE RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2153

File No. 14211

Registered No. 886

County of Boundary

City of Sandpoint (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Horn

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	single

6. DATE OF BIRTH

X (Month) (Day) 1 (Year)

7. AGE

..... yrs. ..... mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sandpoint Idaho.

10. NAME OF FATHER Olaf Horn.

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER /

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) N. L. Ellerstad

(Address) Sandpoint, Ida.

15.

Filed May 16 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 15 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1916, to May 15 1916, that I last saw h[illegible] alive on May 14 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature birth - 5½ months gestation

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.

May 15 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: May 16 1916

20. UNDERTAKER: E M Brown — ADDRESS: S P

Boundary Co., Ptrs. & Bdrs. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2165

File No. 14212

City of Sandpoint

(No. ....., ... St.)

Registered No. 887

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza M. Hart

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	married

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

7. AGE

75 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... housewife

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Liman Doolittle

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Mitch

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roland Johnson

(Address) Sand Point Ida

15.

Filed May 18 1916. M McKinnon

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May (Month) 17 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1916., to May 17 1916, that I last saw her alive on May 16 1916, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Hemorrhage from stomach
Gastric ulcer - Had an
Intercapsular fracture of femur
Feb 12

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Ulcer of Stomach

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.

May 1 1916 (Address) Sand Point

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Ida	May 20 1916

20. UNDERTAKER	ADDRESS
E M Brower	S P

CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2155

File No. 14213

City of Sandpoint

(No. ....., ... St.)

Registered No. 82

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lillian Bass

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	married

6. DATE OF BIRTH

..... 1
(Month) (Day) (Year)

7. AGE

95 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... housewife

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Nebraska

10. NAME OF FATHER Alfred Funk

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Phebe Gates

13. BIRTHPLACE OF MOTHER (State or Country) Green Lowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. A. Bass

(Address) Eagle Ida.

15.

Filed May 21 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 20 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 22 1916, to May 20 1916, that I last saw her alive on May 20 1916, and that death occurred on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

Uremia (Puerperal)

..... (Duration) ..... yrs. 2 mos. 6 ds.

Contributory (Secondary) Child birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.

May 21 1916 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Tilden Nebraska | DATE OF BURIAL May 22 1916

20. UNDERTAKER E M Brower | ADDRESS S.P.

N. B.—Every item of information should be carefully supplied. AGE should be stated CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2135

File No. 14214

City of Sandpoint

(No. ....., ... St.)

Registered No. 871

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Bergstrom

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

.....yrs. .....mos. .....ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. Brown

(Address) Sandpoint

15.

Filed May 29 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 28 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1916, to May 28 1916, that I last saw h— alive on May 27 1916, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

.....(Duration).....yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) F. B. Barnum M D

6/7 1916 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint	May 31 1916
20. UNDERTAKER	ADDRESS
O. M. Brown	S. P.

Ment of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 2133

File No. 14215

County of Bonner

City of Sandpoint (No. ....., ... St.)

Registered No. 884

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frances Banker

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH

Jan (Month) 24 (Day) 1855 (Year)

7. AGE

61 yrs. 3 mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Laborer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER Steven Banker

11. BIRTHPLACE OF FATHER (State or Country) Wis.

12. MAIDEN NAME OF MOTHER Diana Kenney

13. BIRTHPLACE OF MOTHER (State or Country) .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. L. Banker

(Address) Kootenai Idaho

15.

Filed May 7 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1915, to May 1916, that I last saw her alive on May 3rd 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease
Had Pneumonia Lober
two weeks before the died

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory I
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.

May 6 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Idaho	May 8 1916

20. UNDERTAKER	ADDRESS
C M Brown	S D

SYMS - YORK CO., PTRS. & BDRS. 19760

DEATHS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2105

File No. 14216

City of Sandpoint (No. ....., ... St.)

Registered No. 883

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles M. Gehringer

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH

..... (Month) ..... 1 (Day) (Year)

7. AGE

59 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry business, or establishment in which employed (or employer) Teamster

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER Alfred Gehringer

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Slanker

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M J Gehringer

(Address) Blacktail Ida.

15.

Filed May 16 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 15 1916

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1916, to April 20 1916, that I last saw him alive on April 20 1916, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) One year

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.

May 16 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Ida	May 17 1916
20. UNDERTAKER	**ADDRESS**
E M Brown	S P

CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. ment of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

MARGIN RESERVED FOR BINDING

...TE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSI-
...item of information should be carefully supplied. AGE should be stated EXACTLY.
...should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
...t of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 1421
Registered No. 18

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Nicholls

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Oct (Month) 24 (Day) 1852 (Year)

7. AGE: 63 yrs. 7 mos. 6 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Household wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn

10. NAME OF FATHER: Fredric Sexton

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Nicholls
(Address) Grangeville Ida.

15. Filed June 1 1916 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1916 to May 24 1916 that I last saw h[er] alive on May 24 1916, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.
5/26 1916 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grangeville Cem. | DATE OF BURIAL: 5/27 1916

20. UNDERTAKER: W E Graham | ADDRESS: Grangeville

...YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 14218
Registered No. 77

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Hannah D. Munro

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: April (Month) 23 (Day) 1860 (Year)

7. AGE: 56 yrs. mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: John Leuschman

11. BIRTHPLACE OF FATHER (State or Country): New Hampshire

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): New Hampshire

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H D Munro
(Address) Grangeville Idaho

15. Filed June 1 1916 G D Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916 to May 17 1916 that I last saw her alive on May 16 1916 and that death occurred on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:
Rheumatism with Hemorrhagic Purpura
(Duration) yrs. mos. 14 ds.
Contributory (Secondary) La grippe
(Duration) yrs. 4 mos. 14 ds.
(Signed) G D Stockton M. D.
5/17 1916 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Prairie View	May 18 1916

20. UNDERTAKER	ADDRESS
W E Graham	Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14219
Registered No. 15

1. PLACE OF DEATH. Registration District No. 103
County of Idaho
City of Denver (No. ..., ... St.)
Primary Registration District No. 218/
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John Ogden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Not obtainable (Month) (Day) 1 (Year)
7. AGE: About 45 yrs. ... mos. ... ds. IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Day laborer
(b) General nature of industry business or establishment in which employed (or employer): ...
9. BIRTHPLACE (State or Country): Not obtainable
10. NAME OF FATHER: Not obtainable
11. BIRTHPLACE OF FATHER (State or Country): Not obtainable
12. MAIDEN NAME OF MOTHER: Not obtainable
13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse L Ramey
(Address) Wrangell Alaska
15.
Filed June 8 1916 G S Stuckslen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ... 191..., to ... 191... ~~that I last saw h~~ alive on ... 191..., ~~and that~~ death occurred on the date stated above, at 6.50 P. M.
The CAUSE OF DEATH* was as follows:
Shock and Hemorrhage following accident
... (Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary) ...
... (Duration) ... yrs. ... mos. ... ds.
(Signed) Jesse L Ramey M. D.
June 8 1916 (Address) Wrangell Alaska

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Portland Oregon
DATE OF BURIAL ... 191...
20. UNDERTAKER: W E Graham
ADDRESS Wrangell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS-YORK CO., PRINTERS & RULERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 3

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14220

Registered No. 40

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Greenleaf

If death occurs away from usual residence, give facts called for under special information.

Registration District No.....

Primary Registration District No. 2005

(No. ....., ... St.)

2. FULL NAME Marcelica Henley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 20 (Day) 1914 (Year)

7. AGE: 1 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Joseph A Henley

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Lydia Neuperk

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. Henley

(Address) Greenleaf Idaho

15. Filed 5-12-1916 John D. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1916, to May 8 1916, that I last saw h.r alive on May 8 1916 and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Whooping Cough

.....(Duration ..... yrs. ..... mos. 21 ds.

(Signed) M. D.

5/12 19/6 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 5-12-1916

20. UNDERTAKER: Beckham Case Co ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

File No. 14221

Registered No. 41

County of Canyon

City of Caldwell Rural (No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Horace Rowland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. July (Month) 10 (Day) 1851 (Year)

7. AGE: 64 Yrs. 10 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Texas

10. NAME OF FATHER Anderson Rowland

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Ruth Woods

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs J D Rowland
(Address) Caldwell

15. Filed 5-24- 1916 — John D. Myers, Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 14 1916, to May 23 1916, that I last saw her alive on May 23 1916 and that death occured on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Pernicious Anemia

about 3 mos. (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
5/24 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: May 24 1916

20. UNDERTAKER: W. C. Dyer — ADDRESS: Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon — Primary Registration District No. 2005

City of Caldwell Rural (No. .... St.)

File No. 14222

Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Cox.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Nov. (Month) 13 (Day) 1853 (Year)

7. AGE: 62 Yrs. 6 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Eli Cox

11. BIRTHPLACE OF FATHER (State or Country): don't know

12. MAIDEN NAME OF MOTHER: Mary Mills

13. BIRTHPLACE OF MOTHER (State or Country): don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. C. Cox

(Address) Middleton Idaho

15. Filed 5-24-1916 John S. Meyer Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1916, to May 18 1916, that I last saw him alive on May 15 1916, and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Neuralgia of Heart.
Twenty minutes

— (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) —

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Henry M. D.

5/24/1916 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: May 25 1916

20. UNDERTAKER: W. C. Dyer Caldwell — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 14222
Registered No. 43

1. PLACE OF DEATH.
County of Canyon
City of Greenleaf
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leta Opal Littell.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct 22 1913 (Month) (Day) (Year)

7. AGE: 2 Yrs. 7 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Hiram L Littell

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Silvia Bellville

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. L. Littell
(Address) Greenleaf

15.
Filed May 29th 1916
John H. Meyers
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1916 to May 28 1916, that I last saw h— alive on May 27th 1916, and that death occured on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:
Ileo-Colitis

(Duration) ..... Yrs. ..... mos. 12 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) P. Nelson M. D.
May 29 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: May 30 1916

20. UNDERTAKER: Peckham Case Co. ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14224

Registered No. 44

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

(No. 606 Sou. 6th Ave. St.)

Registration District No 3

Primary Registration District No 1005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matthew Lawson Riddle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.

September (Month) 6 (Day) 1841 (Year)

7. AGE

74 Yrs. 8 Mos. 23 ds. less-

IF LESS than 1 day how many ~~hrs.~~ or ~~min.~~

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York Delaware Co.

10. NAME OF FATHER William Riddle

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Mary Lawson

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mattis Lawson Riddle

(Address) 606 S. 6th Ave. Caldwell, Ida.

15.

Filed May 30 1916

John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29 1916, to May 29 1916, that I last saw h~~im~~ alive on May 29 1916, and that death occured on the date stated above, at 3 ~~89~~ P.M.

The CAUSE OF DEATH* was as follows:

Heart block

(Duration) Sudden death yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) J. M. Lee M. D.

May 29 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill

DATE OF BURIAL: May 31 1916

20. UNDERTAKER: W C Dyer

ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 14225
Registered No. 45

1. PLACE OF DEATH.
County of Canyon
City of Caldwell Res.
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Mary E Brim

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: October (Month) 13 (Day) 1889 (Year)

7. AGE: 26 Yrs. 7 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pleasant Plain Jefferson Co Iowa

10. NAME OF FATHER: Owen W Hopkins

11. BIRTHPLACE OF FATHER (State or Country): Pleasant Plain Iowa Jefferson Co

12. MAIDEN NAME OF MOTHER: Dorie Jones

13. BIRTHPLACE OF MOTHER (State or Country): Brighton Iowa Washington Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Her
(Address) Owen W Hopkins Caldwell Ida

15. Filed 6-6- 1916
John D. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4th 1916, to June 4th 1916, that I last saw her alive on June 4th 1916, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Poison

4 hrs, (Duration) ..... Yrs ..... mos. ..... ds.
Contributory (Secondary) Mitral Valve Insuffi-
ciency (Duration 4 yrs. mos. ds.

(Signed) J. M. Hurry M. D.
June 6 1916. (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greenleaf
DATE OF BURIAL: 6/6 1916

20. UNDERTAKER: W L Dyer
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING - WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 14226
Registered No. 46

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Calvin W. Cochran

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH. Oct (Month) 6 (Day) 1889 (Year)

7. AGE 26 Yrs. 8 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Stockman
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER Robert J Cochran

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Bell White

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Belle Love
(Address) Emmett, Idaho

15. Filed June 8 1916 John L Meyers Local Registrar

SYMS - YORK CO., PTRS. & SDRS. 24859

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:
Drinking & bladdanum
suicidal intent
.....
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) A. A. Fries Coroner
6/7/1916 (Address) Caldwell Canyon Co. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	June 8 1916
20. UNDERTAKER	ADDRESS
Peterham Case Co	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ..... St.)

File No. 14227
Registered No. 177

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elizabeth Close

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Nov. (Month) 22 (Day) 1846 (Year)

7. AGE: 69 Yrs. 6 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. home wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Kentucky

10. NAME OF FATHER William A. Kellar

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Susan M. Garr

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. S. Close
(Address) Canyon Co Ida

15. Filed June 8th 1916 — Jos. H. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June. (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from about Nov 1914, to May 7 1916, that I last saw h[illegible] alive on 6th May 1916 and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Senile [illegible]
(Duration) about 2 yrs. mos. ..... ds.
(Signed) [illegible] M. D.
6/7 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL
Canyon Hill June 8 1916

20. UNDERTAKER. ADDRESS
Pentecost Bros Caldwell

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2072
File No.
Registered No. 14228

1. PLACE OF DEATH.
County of Power
City of Landing (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosalie Hunt

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fm
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: (X) May (Month) 5 (Day) 1916 (Year)

7. AGE: — yrs. — mos. 4½ hours ds.
IF LESS than 1 day how many 4 hrs. or 30 mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Power Co Ida

10. NAME OF FATHER: Clarance Hunt

11. BIRTHPLACE OF FATHER (State or Country): Sloan Iowa

12. MAIDEN NAME OF MOTHER: Anna Morgan

13. BIRTHPLACE OF MOTHER (State or Country): Waco Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarance Hunt
(Address) Rockland

15. Filed May 10 1916 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1916, to May 5 1916, that I last saw her alive on May 5 1916, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Premature birth 6 hrs

(Duration) — yrs. — mos. — ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. H. Hardy M. D.
5/8 1916 (Address) Rockland

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rockland Ida
DATE OF BURIAL: May 7 1916

20. UNDERTAKER: None
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

Primary Registration District No. 2072

File No. 14229

County of Power

City of Lansing (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilma Hunt

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fm

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: X May (Month) 5 (Day) 1916 (Year)

7. AGE: — yrs. — mos. — ds. IF LESS than 1 day how many .. 6 hrs. or 30 mins.?

8. OCCUPATION.
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Power Ida

10. NAME OF FATHER Clarance Hunt

11. BIRTHPLACE OF FATHER (State or Country) Sloan Iowa

12. MAIDEN NAME OF MOTHER Anna Margraue

13. BIRTHPLACE OF MOTHER (State or Country) Wasco Co Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarance Hunt
(Address) Rockland

15. Filed May 10 1916 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1916, to May 5 1916, that I last saw her alive on May 5 1916 and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Premature birth 6 months

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E H Tagle M. D.

5/8 1916 (Address) Rockland Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rockland Ida — DATE OF BURIAL: May 7 1916

20. UNDERTAKER: None — ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14230
Registered No. .....

1. PLACE OF DEATH.
Registration District No. 91
Primary Registration District No. 2168
County of Clearwater
City of Elk River, (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Boyce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): child

6. DATE OF BIRTH. Nov. (Month) 13 (Day) 1908 (Year)

7. AGE: 8 Yrs. 6 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School girl
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Herrison Idaho

10. NAME OF FATHER W W Boyce

11. BIRTHPLACE OF FATHER (State or Country) Maine

12. MAIDEN NAME OF MOTHER Evy Spencer

13. BIRTHPLACE OF MOTHER (State or Country) Penna.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J Dimon
(Address) Elk River Ida.

15.
Filed June 8 1916
Mrs. J. Dimon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8 1916, to June 7 1916, that I last saw her alive on June 7 1916, and that death occured on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:
Acute endocarditis

(Duration) Yrs. 2 mos. ..... ds.
Contributory (Secondary) Acute Dilatation

(Duration) ..... yrs. ..... mos. 10 ds.
(Signed) John Dimon M. D.
June 7 1916 (Address) Elk River, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elk River Idaho — DATE OF BURIAL: June 8 1916

20. UNDERTAKER: none — ADDRESS

N. B.—Every item of information should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BOOK. 24858

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14231
Registered No. 65

1. PLACE OF DEATH. Registration District No. 47
County of Lewis
Primary Registration District No. 2134
City of Nezperce (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mary L Greek.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married
6. DATE OF BIRTH Nov. 16 1863 (Month) (Day) (Year)
7. AGE 52 yrs. 5 mos. 23 ds. IF LESS than 1 day how many.....hrs. or .....min?
8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country) Ohio
10. NAME OF FATHER Marks
11. BIRTHPLACE OF FATHER (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Marks
13. BIRTHPLACE OF MOTHER (State or Country) Not Known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank C Greek
(Address) Nezperce Ida
15.
Filed 5/10 1916 J. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 9 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 31 1916, to May 9 1916
that I last saw h[illegible] alive on May 9 1916
and that death occurred on the date stated above, at 5:30 P. M.
The CAUSE OF DEATH* was as follows:
Mitral Stenosis
.....
.....
Cpl. (Duration) 8 yrs. ..... mos. ..... ds.
Contributory General Oedema
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John L Kelly M. D.
May 10 1916 (Address) Nezperce Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Nezperce
DATE OF BURIAL 5/10 1916
20. UNDERTAKER E. Meeks
ADDRESS Nezperce
Anderson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14232
Registered No. 5

1. PLACE OF DEATH.
County of Lewis
City of Nezperce
Registration District No. 47
Primary Registration District No. 2174
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME. Henry Bedard

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Divorced

6. DATE OF BIRTH: 1 (Month) 1 (Day) 1846 (Year)

7. AGE: 70 yrs. — mos. — ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John L Fuller
(Address): Nezperce

15.
Filed 5-7 1916
J. Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 5 (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27 1916, to May 1 1916, that I last saw him alive on April 30 1916 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

..... (Duration) Many yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Interstitial Nephritis

..... (Duration) 3 yrs. 6 mos. ..... ds.

(Signed) John L Fuller M. D.

5/1 1916 (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nezperce, Idaho
DATE OF BURIAL: 5-3 1916

20. UNDERTAKER: D. P. Donovan
ADDRESS: Nezperce, Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 87

Primary Registration District No. 2104

File No. 14233

County of Wash.

City of Midvale (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Luddington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: May 26 (Month) 1 (Day) (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs.* or ..... *mins.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: E. Cal. Luddington

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Beretha Lyons.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cal Luddington
(Address) Cambridge

15. Filed June 6 1916 W.H. Marshall Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 26 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1916, to May 25 1916, that I last saw h[er] alive on May 25 1916, and that death occurred on the date stated above, at 6.30 M.

The CAUSE OF DEATH* was as follows:

Premature & Malformed Mother

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W.H. Marshall M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge

DATE OF BURIAL: May 26 1916

20. UNDERTAKER

ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
(No. ....., ... St.)

File No. 14234
Registered No. 13

1. PLACE OF DEATH.
County of Elmore
City of Mtn Home

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Wilson Lamberton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, ~~MARRIED~~, WIDOWED ~~OR DIVORCED~~. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 17 (Day) 1882 (Year)

7. AGE: 35 Yrs. 4 Mos. 13 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real-Estate
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Chas H Lamberton

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Imogen Maud Smith

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lester Lamberton Jr
(Address) Edmonds Washington

15. Filed June 1st 1916. E. L. Mather Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 31st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23d 1916, to May 31st 1916, that I last saw him alive on May 31st 1916 and that death occured on the date stated above, at 11.55 P. M.

The CAUSE OF DEATH* was as follows:
miliary tuberculosis

(Duration) Yrs. 1 1/2 mos. 7 ds.
Contributory (Secondary) Pulmonary tuberculosis
(Duration 5 yrs. - mos. - ds.

(Signed) B W Mather M. D.
5/31 1916 (Address) Mountain Home Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise City — DATE OF BURIAL: June 5th 1916

20. UNDERTAKER: J M Cowan — ADDRESS: Mountain Home Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 34

Primary Registration District No. 2020

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14235

Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Elmore

City of Atlanta

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Nelson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unknown (Month) (Day) (Year)

7. AGE: ..... Yrs. 44 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Do

11. BIRTHPLACE OF FATHER (State or Country): Do

12. MAIDEN NAME OF MOTHER: Do

13. BIRTHPLACE OF MOTHER (State or Country): Do

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Davis

(Address) Atlanta

15. Filed June 1st 1916 B. O'Mathey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 30th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25th 1916, to May 30th 1916, that I last saw h. alive on May 30th 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Sawtelle M. D.

19..... (Address) Atlanta Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs. 7 mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Atlanta Idaho | DATE OF BURIAL: May 31st 1916

20. UNDERTAKER: J H Davis | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYMS - YORK eb., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 14236
Registered No. 15

1. PLACE OF DEATH.
County of Elmore
City of Mountain Home
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Powers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Unknown

6. DATE OF BIRTH. Unknown
(Month) (Day) 1 (Year)

7. AGE About 25 yrs
Yrs. Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Unknown

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER
(State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER
(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. H. Easton, Coroner
(Address) Mtn. Home, Idaho,

15.
Filed June 3rd 1916 B. W. Mathus Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 2nd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191...,
that I last saw h— alive on ——— 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Accidental—
Crushed by end of coal car
by shifting of timbers, with which
the car was loaded
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) A. H. Easton, Coroner M. D.
6/7 1916 (Address) Mtn. Home, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Braddock, Pa

19. PLACE OF BURIAL OR REMOVAL Braddock Pa | DATE OF BURIAL .....191...

20. UNDERTAKER J. M. Corgan Mountain Home Ida ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 14237
Registered No. 14

1. PLACE OF DEATH.
County of Elmore
City of Mountain Home
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph L Whitney

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): unknown

6. DATE OF BIRTH.
unknown (Month) (Day) 1 (Year)

7. AGE
about 30 years
.....Yrs. .....Mos. .....Ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Unknown

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER
(State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER
(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. H Eaton, Coroner
(Address) Mtn. Home, Ida.

15.
Filed June 3rd 1916.
H. H Eaton Local Registrar

SYMS-YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 2nd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191..., that I last saw h— alive on ——— 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Accidental
Crushed in end of coal car by shifting timbers, with which the car was loaded

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) H. H Eaton, Coroner M. D.
6/3 1916. (Address) Mtn Home, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Braddock, Pa.

19. PLACE OF BURIAL OR REMOVAL: Braddock Pa
DATE OF BURIAL .....191...

20. UNDERTAKER: J M Corran
ADDRESS: Mtn Home Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 14238
Registered No. 11

1. PLACE OF DEATH.
County of Elmore
City of Burnt Creek (No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Hollebaun

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. May (Month) 16 (Day) 1857 (Year)

7. AGE: 59 Yrs. 1 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Samuel Marshall

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Lena Reed

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. M. Conner Rep. U.S.M.M.
(Address) Mountain Home, Idaho

15. Filed May 2nd 1916 Ben Walker Local Registrar

SYMS - YORK CO., PTRS. & PORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10th 1916, to May 2nd 1916, that I last saw her alive on May 1st 1916, and that death occured on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Cirhosis of liver

(Duration) ..... Yrs. 6 mos. ..... ds.
Contributory (Secondary) La Grippe
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Downs M. D.
May 3 1916 (Address) Glenns Ferry Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: La Junta Colo — DATE OF BURIAL: May 5th 1916

20. UNDERTAKER: J. M. Conner M.D. — ADDRESS: Mtn Home Ida

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14239
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
Registration District No. 52
Primary Registration District No. 2136
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Baby Boothe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH (X) July 27th 1915
(Month) (Day) (Year)

7. AGE ..... yrs. 10 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Infant
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Montpelier Idaho

10. NAME OF FATHER Louis Boothe

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Sorenson.

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis Boothe
(Address) Montpelier Idaho

15. Filed May 31st 1916 — H. W. Kling M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 31st 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29th 1916, to May 31st 1916
that I last saw h[illegible] alive on May 31st 1916
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) Measles
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. W. Kling M. D.
May 31st 1916 (Address) Montpelier Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Montpelier Ida. — DATE OF BURIAL 6/1 1916

20. UNDERTAKER Barbach — ADDRESS Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52

Primary Registration District No. 2136

File No. 14240

Registered No.

1. PLACE OF DEATH.

County of Bear Lake

City of Sharon

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Doris Schreiber

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH October (Month) (Day) 1914 (Year)

7. AGE One yrs. Six mos. ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Sharon Ida.

10. NAME OF FATHER Henry Schreiber

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Sadie Winans

13. BIRTHPLACE OF MOTHER (State or Country) Liberty Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. E. Hymas

(Address) Sharon Idaho

15. Filed June 1st 1916 W. H. King Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Apr. (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Cause not known

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leo F. Cahill Coroner M. D.

19.... (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sharon Ida. DATE OF BURIAL Apr 16 191..

20. UNDERTAKER Bishop Hymas ADDRESS Sharon

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14241

Registered No.

1. PLACE OF DEATH.

Registration District No. 52

County of Bear Lake

Primary Registration District No. 2136

City of Montpelier (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen A Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Feb (Month) 5 (Day) 1863 (Year)

7. AGE: 53 yrs. 4 mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House-wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: David Taylor ~~David Cox~~

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Isabel Cox

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Lynn
(Address) Montpelier Ida.

15. Filed June 8th 1916. W H Lee MD Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1915, to June 4th 1916, that I last saw her alive on June 4th 1916, and that death occurred on the date stated above, at 8.30 P.M.

The CAUSE OF DEATH* was as follows: -
cancer of liver

(Duration) 1 yrs. mos. ds.

Contributory (Secondary) Insanition

(Duration) yrs. 5 mos. ds.

(Signed) J. W. Lynn M. D.

June 7 1916 (Address) Montpelier Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier DATE OF BURIAL: June 7 1916

20. UNDERTAKER: F. M. Williams ADDRESS: Montpelier

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 52

County of Bear Lake Primary Registration District No. 2136

City of Newman (No. ....., ... St.)

File No. 14242

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Joan Chugg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
female	white	married

6. DATE OF BIRTH: Jan. (Month) 2 (Day) 1829 (Year)

7. AGE: 87 yrs. [redacted] mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: [redacted] farmers wife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Isaac Hamell

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ella Jones

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Lyman

(Address) Montpelier Idaho

15. Filed June 4th 1916 A. W. Kenyon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1915, to June 1 1916, that I last saw her alive on May 28 1916, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) — yrs. 9 mos. — ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Lyman M. D.

19 ..... (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Newman Idaho — DATE OF BURIAL: 6/4/1916

20. UNDERTAKER: Nephi Skinner — ADDRESS: Newman

1. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 14243
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Fish Haven
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John C Churchman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	Single

6. DATE OF BIRTH
March 23 1841
(Month) (Day) (Year)

7. AGE
25 yrs. 2 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Denmark Iowa

10. NAME OF FATHER John C Churchman

11. BIRTHPLACE OF FATHER
(State or Country) Denmark Iowa

12. MAIDEN NAME OF MOTHER Catherine Hayden

13. BIRTHPLACE OF MOTHER
(State or Country) Denmark Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr J W Lyons
(Address) Montpelier Idaho

15.
Filed June 1 1916 H W Rue
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 26 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1916, to May 24 1916, that I last saw h alive on May 14 1916 and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Leakage of heart
(Duration) one yrs. ..... mos. ..... ds.
Contributory
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr J W Lyons M. D.
19 .... (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death one yrs. ..... mos. ..... days. In the State 6 yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? Fish Haven
Former or usual residence Denmark Iowa

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fish Haven	May 26 1916
20. UNDERTAKER	ADDRESS
L Gardner	Garden

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14244

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of Buhl

(No. ....., ... St.)

Registration District No. 39

Primary Registration District No. 2081

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME May Marie Heidle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH. March 20 1906
(Month) (Day) (Year)

7. AGE ..... Yrs. 2 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Buhl

10. NAME OF FATHER John Heidle

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Maud Glauder

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Heidel

(Address) Buhl

15. Filed 5-21 1916

J. H. Nuckolls
Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 21 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1916, to May 21 1916, that I last saw her alive on May 20 1916, and that death occured on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Whooping Cough

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. B. Evans M. D.

May 22nd 1916. (Address) Buhl Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl Ida	5/21 1916

20. UNDERTAKER	ADDRESS
A. B. Evans	Buhl.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 31
Primary Registration District No. 3687
(No. ....., ... St.)

File No. 14245
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harriet Augusta Hart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	American	Widowed

6. DATE OF BIRTH
Oct. 5 (Month) 5th (Day) 1837 (Year)

7. AGE
79 yrs. 7 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Quincy, N. H.

10. NAME OF FATHER Herman Wright.

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Youngman

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Stella Hart Van Riper
(Address) Buhl Ida

15.
Filed 5-3 1916. J. K. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1916; to May 1 1916, that I last saw her alive on May 1 1916, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Uremia.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Parenchymatous Nephritis
..... (Duration) Not given yrs. ..... mos. ..... ds.
(Signed) J. K. Murphy M. D.
5-1 1916. (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ REMOVAL: La Porte Ida — DATE OF BURIAL ..... 191...

20. UNDERTAKER: Homer B. Evans — ADDRESS: Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls. Registration District No. 39
City of Buhl. Primary Registration District No. 1091
(No. ....., ... St.)
File No. 14247
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert B Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	Married

6. DATE OF BIRTH
January - 21 1866
(Month) (Day) (Year)

7. AGE
50 yrs. 4 mos. No ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Formerly Physician
(b) General nature of industry business, or establishment in which employed (or employer) Now, Farmer

9. BIRTHPLACE
(State or Country) Helsingborg, Sweden,

10. NAME OF FATHER Andrew Nelson

11. BIRTHPLACE OF FATHER
(State or Country) Sweden

12. MAIDEN NAME OF MOTHER Benedeta Nelson

13. BIRTHPLACE OF MOTHER
(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ada E Nelson
(Address) Buhl, Idaho

15.
Filed May - 23 1916 J. A. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 21 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1916, to May 17 1916
that I last saw him alive on May 17 1916,
and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Acute Dilitation of Heart.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) La Grippe.
..... (Duration) ..... yrs. ..... mos. 6 ds.

(Signed) J. A. Murphy M. D.
5-22 1916 (Address) Buhl Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....., yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl Ida | DATE OF BURIAL: 5-24 1916.

20. UNDERTAKER: J. E. Schmidt | ADDRESS: Buhl Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & SONS 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14249

Registered No. 28

1. PLACE OF DEATH.

County of Boise

City of

Registration District No. 8

Primary Registration District No. 2004

(No.) Kempner Ranch Boise Co.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred Milton Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. (Month) (Day) 1876 (Year)

7. AGE: 39 Yrs. 7 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: John Baker

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Sarah Ann Malley

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Baker

(Address) Star Idaho

15. Filed May 30 1916 E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased from Dead May 28 1916, to ~~and~~ ~~191~~, that I last saw him alive on 28th March 1916, and that death occured on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Had Stomach trouble for the past two years took very sick Friday last with one of the spells and died on the way to Boise Hospital (Duration ~~Yrs.~~ ~~mos.~~ ~~ds.~~) Contributory (Secondary) without medical attendance. (Duration yrs. mos. ds.)

(Signed) Frank B. Baker M. D.

19 (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..yrs..mos..days. In the State ..yrs..mos..days

Where was disease contracted if not at place of death?

Former or usual residence ~~Shipman~~

19. PLACE OF BURIAL OR REMOVAL: Boise Ida. DATE OF BURIAL: May 30 1916

20. UNDERTAKER: Schreiber & Redmond ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

CERTIFICATE OF DEATH

STATE OF IDAHO
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City or Boise (No. 1010 Eldredge Ave. St.) Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert C. Worthington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. (Month) Dec (Day) 20 (Year) 1841

7. AGE: 75 Yrs. 4 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Veteran Civil War
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER A. Worthington

11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lyman C. Worthington
(Address) 2007 N. 8th

15. Filed May 20 1916 E. F. Calvin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) 5 (Day) 19 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/1 1916, to 5/19 1916
that I last saw him alive on 5/16 1916
and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. .....

(Signed) F. H. Clough M. D.

5/19 1916 (Address) Idaho Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery | DATE OF BURIAL: May 20 1916

20. UNDERTAKER: Frye & Summers | ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
(No. ....., ... St.)

File No. 14251
Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ada.
City of Meor Boise.

2. FULL NAME Frances E. Friedly

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sep (Month) 23 (Day) 1863 (Year)

7. AGE: 52 Yrs. 8 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Thomas J. Brickell.

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Elizabeth Brickell.

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R H Friedly
(Address) .....

15. Filed May 31 1916
E. J. Lukes
Local Registrar

SYMS - YORK CO., PTGS. & SOES. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28th 1916, to May 28th 1916, that I last saw h[illegible] alive on May 28th 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) Chronic Heart Lesion

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm Baird M. D.

5-29-1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem
DATE OF BURIAL: May 31 1916

20. UNDERTAKER: Frye Sommer Co.
ADDRESS: Boise Ida.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

8

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14252

Registered No. 30

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

County of Ada

City of Boise (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm A. Lintecum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Marr

6. DATE OF BIRTH: Sept (Month) 11 (Day) 1882 (Year)

7. AGE: 33 yrs. 8 mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Albert Lintecum

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Melinda Pope

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs W.A. Lintecum
(Address): Boise Idaho R 7 Box 7

15. Filed May 30 1916 E.J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1916, to May 29 1916, that I last saw h in alive on May 29 1916 and that death occurred on the date stated above, at 8 55 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Intraculosis

5

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) 6 yrs. 2 mos. ..... ds.

(Signed) Edward H Bowes M. D.

May 30 1916 (Address) 706 Yeats Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: June 3 1916

20. UNDERTAKER: Gray & Summers — ADDRESS: Boise Idaho

SYMS - YORK CO. STRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004

File No. 14253
Registered No. [illegible]

1. PLACE OF DEATH.

County of Ada
City of 5 Miles west Boise (or 5 Miles W. of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Parry Goodman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Sept (Month) [illegible] (Day) 1860 (Year)

7. AGE: 55 Yrs. 8 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Putnam Co., Mo.

10. NAME OF FATHER: Geo W. Goodman

11. BIRTHPLACE OF FATHER (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Zintha A. Gilbert

13. BIRTHPLACE OF MOTHER (State or Country): Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G.W. Goodman
(Address) Boise Ida

15. Filed May 31 1914 — E.J. Seale, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/11 1916, to May 12 1916, that I last saw h[illegible] alive on May 12 1916, and that death occured on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:
1 Hemiplegia

(Duration) Yrs. mos. ds.
Contributory (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) Fred A. Ustick M. D.
5/31 1916 (Address) Galt Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? [illegible]
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/1 1916

20. UNDERTAKER: Schneider & Anderson — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 1815 Harrison Blvd St.)

File No. 1225

Registered No. 14254

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Isaac Ouradu

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. (Month) 9th (Day) 1915 (Year)

7. AGE: Yrs. 4 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Albert Ouradu

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Lizzie A. Moore

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Ouradu

(Address) Boise R #3 Ida

15. Filed 5/7 191.....

E. J. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/5 1916, to 5/6 1916, that I last saw h[illegible] alive on 5/6 1916 and that death occured on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Morbus Mascularis
Neonatorum

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs .....mos. .....ds.

(Signed) Fred A. Tefft M. D.

5/6 1916 (Address) Falk Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/8 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BSRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. N

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14256

Registered No. 131

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Florence Emma Hendrix

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. (Month) 16 (Day) 1913 (Year)

7. AGE: 2 Yrs. 5 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: William Lester Hendrix

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Florence Alice Lindsay

13. BIRTHPLACE OF MOTHER (State or Country): Boise

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. J. Hendrix.

(Address) R. D. No 5 Boise Ida.

15. Filed 5-29- 1916

E. J. Patory
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/25 1916, to 5/28 1916, that I last saw her alive on 5/28 1916, and that death occured on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:

Interstitial Meningitis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Whooping Cough

(Duration) Yrs. mos. ds.

(Signed) F. H. Sullivan M. D.

5/29 1916 (Address) Salt Lake Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence Ida Boise Ida.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: 5/30 1916

20. UNDERTAKER: Schmidt & Hedegaard

ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14254
Registered No. 130

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.

Registration District No. 27
Primary Registration District No. 1004

County of Ada
City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Michael Jordan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. March 29 (Month) (Day) 1839 (Year)

7. AGE 77 Yrs. 2 Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Jessie Jordan

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Elizabeth Dyson Jordan

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred R. Jordan

(Address) 1021 Hays St Boise Ida

15. Filed May 29 1916 E. J. Cator Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 28 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1916, to May 28 1916, that I last saw h... alive on May 28 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of bladder

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery — **DATE OF BURIAL** 5/29 1916

20. UNDERTAKER Schreiber & Sidinger — **ADDRESS** Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14258

Registered No. 129

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 7 x Ada St.)

Registration District No.

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hannah Earley.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. about (Month) (Day) 1840 (Year)

7. AGE about 75 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... retired Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Patrick Rogan

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary Rogan

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie Rock

(Address) Boise Ida

15. Filed 5/26 191 6

E. J. Coston
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 25th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1916, to May 25 1916, that I last saw h.r. alive on May 25. 1916, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Senile decay

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Myocarditis

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. R. McCall M. D.

19..... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: May 29 1916

20. UNDERTAKER: Schreiber & Siedentopf — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 14259
Registered No. 1282

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 203 N Walnut St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helena Kinney Bledsoe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. Nov (Month) 30 (Day) 1842 (Year)
7. AGE: 73 Yrs. 5 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): New York
10. NAME OF FATHER: James Kinney
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Mary Fleming
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. H. Bledsoe
(Address) 203 N Walnut St Boise Ida
15. Filed 5/28 1916 E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 1915, to May 27 1916, that I last saw h-er alive on May 27 1916 and that death occured on the date stated above, at 12-55 PM
The CAUSE OF DEATH* was as follows: Carcinoma of Stomach
(Duration) 1 Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.
(Signed) H. M. Kelsey M. D.
5/28 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: May 29 1916
20. UNDERTAKER: Gray & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

CERTIFICATE OF DEATH

STATE OF IDAHO
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 14260
Registered No. 1471

County of Ada
City of Boise (No. 111 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

NAME OF DECEASED: Elmyra McAllister

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. (Month) Mar (Day) 4 (Year) 1862

7. AGE: 64 Yrs. 2 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Ag Shelley

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Jennie Goodnuf

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. G. McAllister
(Address) Star Idaho

15.
Filed 5/25 1916
E. J. Catron
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1915, to May 24 1916, that I last saw h[er] alive on May 23 1916, and that death occured on the date stated above, at 7.00 M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease
Cerebral Haemorage

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Arteria Sclerosis
(Duration) 3 yrs. mos. ds.

(Signed) R. C. Hunt M. D.
May 25 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 27 1916

20. UNDERTAKER: Frys Funeral Home — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 410 State St.)

File No. 14261

Registered No. 1126

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert William Jullion

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. (Month) 2 (Day) 1911 (Year)

7. AGE: 4 Yrs. 6 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Ida

10. NAME OF FATHER: John Jullion

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Mary Peters

13. BIRTHPLACE OF MOTHER (State or Country): Tel.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Jullion

(Address) Boise Idaho

15. Filed 5/22 1916

E. F. Caton.
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1916, to May 21 1916, that I last saw him alive on May 20 1916, and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Shock from fracturing Skull and Spinal concussion, Etc.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. P. McCalla M. D.

19..... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: May 23 1916

20. UNDERTAKER: Schreiber & Hiden Boise — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 14262
Registered No. 125

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph T. Rocha

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced
6. DATE OF BIRTH. (Month) (Day) (Year): —— 1
7. AGE: About 84 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): California
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): U S
12. MAIDEN NAME OF MOTHER: U
13. BIRTHPLACE OF MOTHER (State or Country): U S
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): A Schreiber
(Address): Boise
15. Filed 5/17 1916
E J Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 17 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 1914, to May 15 1916, that I last saw h— alive on May 10 1916, and that death occured on the date stated above, at 3 P M.
The CAUSE OF DEATH* was as follows:
Cerebral Haemorrage
(Duration) 3 Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration ... yrs. ... mos. ... ds.
(Signed) R E Shurtz M. D.
May 17 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence: Boise

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 5/18 1916
20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 1004
File No. 14263
Registered No. 124

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 301 Jefferson St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Berta Hollenbeak.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. March (Month) 12 (Day) 1864 (Year)

7. AGE: 52 Yrs. 2 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Regensburg Germany

10. NAME OF FATHER Jacob Wireman.

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Emma Oberdorfer

13. BIRTHPLACE OF MOTHER (State or Country) Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. Jack Hollenbeak
(Address) 301 Jefferson.

15. Filed 5/17 1916
E. H. Eaton
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible] to 4/50 1916, that I last saw h[illegible] alive on ..... 191..., and that death occured on the date stated above, at 10-30 M.

The CAUSE OF DEATH* was as follows:

Coma
Saw the body at
Last

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cerebral

(Duration 2 yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 18 1916

20. UNDERTAKER: Schneider & Siebenforbe — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14264

Registered No. 123

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 110 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Theodie Burton Feltner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 11 (Day) 1897 (Year)

7. AGE: 18 Yrs. 7 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... High School
(b) General nature of industry, business, or establishment in which employed (or employer)..... Student

9. BIRTHPLACE (State or Country) Kentucky

10. NAME OF FATHER J T Feltner

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Lelia M Styles

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Leila M. Feltner
(Address) 503 So. 15th St.

15. Filed 5/16 1916 E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 15th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8th 1916, to May 15th 1916, that I last saw him alive on May 15th 1916, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Peritonitis - following
Appendicitis —

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John Breck M. D.

5-16 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: May 17 1916

20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14265

Registered No. 122

1. PLACE OF DEATH.

County of Ada.

City of Boise.

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry C. Olney.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. — (Month) — (Day) 1843 (Year)

7. AGE: 74 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real Estate.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not Known

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. J. Morgan
(Address) Kellogg Idaho

15. Filed 5/16 1916

E. J. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191— to — 191—, that I last saw h— alive on May 15th 1916, and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis
(Sudden death + Ehophy)

— (Duration) — Yrs. — mos. — ds.

Contributory (Secondary)

— (Duration — yrs. — mos. — ds.

(Signed) ..... M. D.

19— (Address) ..... Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: May 1916

20. UNDERTAKER: Frye Summers. ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & BOBS. 24653

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14266

Registered No. 121

Registration District No. 2

Primary Registration District No. 1004

(No. 605 Warm Springs Ave St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel T. M. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. November 21st 1842 (Month) (Day) (Year)

7. AGE: 73 Yrs. 5 Mos. 25 ds.

If less than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Capitalist

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Medydy Kennebec Co. Maine

10. NAME OF FATHER: Samuel Smith M. D.

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Mary Dickerson

13. BIRTHPLACE OF MOTHER (State or Country): Massachusetts

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Asher A. Mitchell

(Address) Idaho City Idaho

15. Filed 5/17 1916

E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1915; to May 16 1916, that I last saw h.. alive on May 15 1916, and that death occured on the date stated above, at 9A M.

The CAUSE OF DEATH* was as follows:

Pyelonephritis (chronic)

(Duration) 5 Yrs. mos. ds.

Contributory (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) Maynard Ballenger M. D.

5/16 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 18 1916

20. UNDERTAKER: Schreiber & Siebenpfeiffer — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

6-7165 - YORK CO., PTRS. & STNRS. 24854

FORM No. 6 25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14267

Registered No. 120

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 412 S State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Comodore David Gillet

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May 6 1887
(Month) (Day) (Year)

7. AGE: 29 Yrs. — Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Street Car
(b) General nature of industry, business, or establishment in which employed (or employer): Conductor

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: W J Gillet

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Nettie Corbin

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W L Gillet
(Address) Boise Idaho

15. Filed 5/16 1916 E F Lafferty Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 15 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1916, to May 15 1916, that I last saw h[illegible] alive on May 15 1916 and that death occured on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculor Peritonitis

(Duration) — Yrs. 5 mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) [illegible] M. D.

19.... (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill

DATE OF BURIAL: 5/17 1916

20. UNDERTAKER: Fry & Summers

ADDRESS: Boise Idaho

BYRD - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14268

Registered No. 119

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jerome E. Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Not Obtainable 1864
(Month) (Day) (Year)

7. AGE: 75 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Not Obtainable

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. G. Burnett
(Address) Boise Idaho.

15. Filed 5/13 1916 E. J. Eaton Local Registrar

SYMS - YORK CO. PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 13 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1916, to May 12 1916, that I last saw him alive on May 12 1916 and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration 2 yrs. ..... mos. ..... ds.

(Signed) Jas Callaway M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or ~~Recent~~ Residents.)
At place of death ..... yrs. ..... mos. 11 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill | DATE OF BURIAL: 5/14 1916

20. UNDERTAKER: Fry & Summers | ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14269
Registered No. 118

1. PLACE OF DEATH.

Registration District No. ....

Primary Registration District No. 1 004

County of Ada

City of Boise (No. 508 Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME B. F. Shepherd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. June (Month) 19 (Day) 1853 (Year)

7. AGE: 62 Yrs. 10 mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Henry Shepherd

11. BIRTHPLACE OF FATHER (State or Country): Vir.

12. MAIDEN NAME OF MOTHER: Amy Logsdon

13. BIRTHPLACE OF MOTHER (State or Country): Vir

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. M. Shepherd
(Address) Boise

15. Filed 5/13 1916 E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1916, to May 10 1916, that I last saw h alive on May 10 1916 and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Mitral regurgitation & stenosis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Auricular fibrillation

(Duration ... yrs. 6 mos. ... ds.

5/13 1916 (Signed) Maurice B. Faulkner M. D.
(Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: El Paso Ill. DATE OF BURIAL: 5/13 1916

20. UNDERTAKER: Schreiber & Sidenfaden ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14270

Registered No. 119

1. PLACE OF DEATH.

Registration District No. V

Primary Registration District No. 1004

County of Ada

City of Boise (No. 317 E. Jeff. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jose Gestal

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June 5th (Month) 1853 (Day) (Year)

7. AGE 62 Yrs. 11 Mos. 5 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Restaurant
(b) General nature of industry, business, or establishment in which employed (or employer)..... Sheep business

9. BIRTHPLACE (State or Country) Santa Eulalia de Moar

10. NAME OF FATHER Jose Gestal

11. BIRTHPLACE OF FATHER (State or Country) Cadiz Spain

12. MAIDEN NAME OF MOTHER Josepha Garcia

13. BIRTHPLACE OF MOTHER (State or Country) Cadiz Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Narcisa Gestal
(Address) 317 E. Jefferson Ste.

15. Filed 5/11 1916 E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1916, to May 10 1916, that I last saw h— alive on May 9th 1916 and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

acute pneumonia

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) Geo Callum M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 5/12 1916

20. UNDERTAKER: Schreiber & Hildenbrand — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 14271

Registered No. 116

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Laura Wills

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Mar (Month) 29 (Day) 1891 (Year)

7. AGE: 25 Yrs. 1 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wash.

10. NAME OF FATHER J. W. Benedict

11. BIRTHPLACE OF FATHER (State or Country) Unn

12. MAIDEN NAME OF MOTHER Mary Bennett

13. BIRTHPLACE OF MOTHER (State or Country) Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Wills

(Address) Barberton Idaho

15. Filed 5/10 1916

E. S. Catlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/4 1916 to 5/9 1916 that I last saw her alive on 5/8 1916 and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 1 Yrs. (?) mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Ralph Hall M. D.

5/6 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Barberton Ida.

19. PLACE OF BURIAL OR REMOVAL: Wardlock Wash. DATE OF BURIAL: 5/10 1916

20. UNDERTAKER: Schreiber & Sidenfaden ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 14272
Registered No. 115

1. PLACE OF DEATH.
County of Ada.
City of Boise.
(No. 1301 No 15 St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Manford Hall.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec 11 (Month) (Day) 1872 (Year)

7. AGE: 73 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio.

10. NAME OF FATHER Cornelius Hall.

11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas C Hall
(Address) .....

15. Filed 5/8 1916. E S Eaton Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1916, to May 5 1916, that I last saw him alive on May 5 1916, and that death occured on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Cancer
(Duration 2 yrs. ..... mos. ..... ds.
(Signed) O H Parker M. D.
19..... (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: 5/8 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14273

Registered No. 114

1. PLACE OF DEATH.

County of Boise

City of Idaho (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francisco Olaechea

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 56 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Pablo Olaechea

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Catalina Zabala

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bernardo Arregui

(Address) .....

15. Filed May 3 1916

E. J. Cator
Local Registrar

SYMS - YORK CO. TYPE & SUPP. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1916 to May 8 1916, that I last saw him alive on May 8 1916, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

General Paresis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred C. Ellsworth M. D.

May 8 1916 (Address) Idaho Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	May 10 1916

20. UNDERTAKER	ADDRESS
Silvercruys & Sidenfaden	Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 40, East Bannock St.)

Registration District No. 2

Primary Registration District No. 1004

File No. 14274

Registered No. 113

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Hoff.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 63 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Durdall

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Brita Durdall

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Odin Hoff

(Address) Meridian

15. Filed 5/9 1916

E. J. Cathy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 10 1916, to May 8 1916, that I last saw h[illegible] alive on May 8 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
& Cardiac Dilitation

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James L. Alvord M. D.

5/9 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Lakeport Lan

19. PLACE OF BURIAL OR REMOVAL: Lakeport Lan — DATE OF BURIAL: 5/10 1916

20. UNDERTAKER: Schmitz & Hidmford — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14275
Registered No. 111

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 1407 N. 10th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lizzie Benner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 7 (Month) November (Day) 18[illegible] (Year)

7. AGE: 62 Yrs. 7 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Wilson Gray Robb

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Eliza Williams

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. B. Peterson
(Address) Honeyhon Route 2 Box

15. Filed 5/6 191 6

E. J. Caton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 4 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1913, to May 4 191[illegible], that I last saw h[illegible] alive on May 4 1916, and that death occured on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:
Acute Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) [illegible] M. D.

19[illegible] (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/7 191 6

20. UNDERTAKER: Schreiber & Sedgwood — ADDRESS: Boise

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 14276

Registered No. 110

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Teodoro Arcaraza

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 23 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Sheepherder

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Abadiano, Spain

10. NAME OF FATHER: Arcaraza

11. BIRTHPLACE OF FATHER (State or Country): Abadiano, Spain

12. MAIDEN NAME OF MOTHER: Pilar Mendiolagarreguy

13. BIRTHPLACE OF MOTHER (State or Country): Abadiano Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bernarda Arregui

(Address) Boise Idaho

15. Filed 5/4 191 6

E. F. Caton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20 1916, to May 2 1916, that I last saw him alive on May 1 1916, and that death occured on the date stated above, at 3A M.

The CAUSE OF DEATH* was as follows:

Tick Fever

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred A Fleming M. D.

5/4 1916 (Address) Falk

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 5-5 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14277
Registered No. 109

1. PLACE OF DEATH.
County of Ada.
City of Boise
(No. 1819 No 18 St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William W West.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 13 (Day) 1 (Year)

7. AGE: 77 Yrs. 7 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): ———

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Alvin West.

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Al West
(Address) Dickey Idaho

15. Filed 5/5 1916
E. S. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29 1916, to May 4 1916, that I last saw h.im alive on May 3 1916, and that death occured on the date stated above, at 1 a. M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Edward Silvers M. D.
5/4 1916 (Address) 306 Yates Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	May 5 1916
20. UNDERTAKER	**ADDRESS**
Guy & Summers	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & STNRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14278
Registered No. 108

1. PLACE OF DEATH.

County of Ada
City of Boise
(No. 111 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004

2. FULL NAME Harvey G Morgan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Not Obtainable (Month) 1 (Day) 847 (Year)

7. AGE: 69 Yrs. ___ Mos. ___ ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Second Hand Furniture
(b) General nature of industry, business, or establishment in which employed (or employer): Dealer

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Martin Jensen
(Address) Caldwell

15. Filed 5/3 191 6

E S Caton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 18 1916, to May 2nd 1916, that I last saw h[im] alive on May 2nd 1916, and that death occured on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:
Cancer of Liver

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J Springer M. D.
May 2 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 5 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Caldwell Idaho — DATE OF BURIAL: May 3 1916

20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

YORK CO., PTRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14279
Registered No. 107

1. PLACE OF DEATH.
County of Ada.
City of Boise.
(No. 1615 Jefferson St.)
Registration District No. 2
Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel R. McLeran.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)
6. DATE OF BIRTH: June 10 1843 (Month) (Day) (Year)
7. AGE: 72 Yrs. ... Mos. ... ds. IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber & Stock
(b) General nature of industry, business, or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Vermont.
10. NAME OF FATHER: Rutherford McLeran
11. BIRTHPLACE OF FATHER (State or Country): Vermont.
12. MAIDEN NAME OF MOTHER: Gleason.
13. BIRTHPLACE OF MOTHER (State or Country): Vermont.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Reuben C. Thompson
(Address) ...
15. Filed 5/1 191 6
E. S. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. 30 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr. 1 1916, to Apr. 30 1916, that I last saw h... alive on Apr. 30 1916, and that death occured on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
Cancer of bowels
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) ... M. D.
19... (Address) ...

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: May 2 1916
20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

4

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 126

Primary Registration District No. 2204

File No. 14280

County of Kootenai

City of Medimont Ida (No. ....., ... St.)

Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Catharine L Huseby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1845 (Year)

7. AGE: 71 yrs. — mos. — ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Edward Lilienthal

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: DK

13. BIRTHPLACE OF MOTHER (State or Country): DK

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ole Huseby. (Son)
(Address) Medimont.

15. Filed June 7 1916 R. H. Gardner Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

..... (Duration) ..... yrs. ..... mos. .....

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Didier M. D.

May 14 1916 (Address) Harrison, Idaho

E. W. DIDIER, M. D. MON MAY 15 1916 HARRISON, IDA.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Medimont - Cem

DATE OF BURIAL: May 16 1916

20. UNDERTAKER: E. Wheeler

ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
(No. ..... , ... St.)

File No. 14281
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Alice vande Steeg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept (Month) 6th (Day) 1915 (Year)

7. AGE Yrs. 8 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Nampa, Idaho.

10. NAME OF FATHER Geo. H. vande Steeg

11. BIRTHPLACE OF FATHER (State or Country) Orange City, Iowa.

12. MAIDEN NAME OF MOTHER May J. Palmer

13. BIRTHPLACE OF MOTHER (State or Country) Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. H. vande Steeg
(Address) Nampa, Idaho

15. Filed June 6 1916 Wm. D. Calaway Local Registrar
Emma Hatfield Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 11 1916, to June 4 1916, that I last saw her alive on June 4 1916, and that death occured on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Dysentries

(Duration) Unascertained mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Clyde Watson M. D.

June 6 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Kohlerlawn Cem — DATE OF BURIAL 6-5 1916

20. UNDERTAKER F. K. Robinson — ADDRESS Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS., BOISE

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 14282
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katherine McGinnis
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH.
Aug (Month) 24 (Day) 1824 (Year)

7. AGE
91 Yrs. 8 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Kentucky

10. NAME OF FATHER: James Carey

11. BIRTHPLACE OF FATHER
(State or Country) ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER
(State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) John McGinnis

15.
Filed May 12 1916 Dist. Registrar
Local Registrar
Signature of Registrar Hatfield Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl 29 1916, to May 2 1916, that I last saw her alive on May 2 1916, and that death occured on the date stated above, at ← M.

The CAUSE OF DEATH* was as follows:
Diabetes, gangrene
(Duration) Yrs. 2 mos. ✓ ds.
Contributory (Secondary) Dropsy
(Duration) ½ yrs. — mos. ..... ds.
(Signed) F B Smith M. D.
5-12 1916 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bellevue Ida
DATE OF BURIAL: 5/13 1916

20. UNDERTAKER: Fred A Robinson
ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 14283
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Dickman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Nov. (Month) 17 (Day) 1844 (Year)

7. AGE: 72 Yrs. 6 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or 15 min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: do not know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. R. Dickman
(Address) box 513 near N. Nampa, Ida.

15. Filed May 22 1916 Dell Calvert Local Registrar
By Estuel Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1915, to May 22 1916, that I last saw him alive on May 7 1916, and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) several Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Bright's Disease
(Duration several yrs. ..... mos. ..... ds.
(Signed) Clyde Watson M. D.
May 22 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 5/24 1916

20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PHILA. 24958

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14284

Registered No.

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

County of Boise

City of McCall, (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sefred Lehbert [illegible]

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	

6. DATE OF BIRTH

Sept 18 (Month) 1915 (Day) (Year)

7. AGE

yrs. 6 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wash

10. NAME OF FATHER Robert O. Brown

11. BIRTHPLACE OF FATHER (State or Country) Wash

12. MAIDEN NAME OF MOTHER Laura E. Lehbert

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Laura E. Lehbert

(Address) Robert Wash

15.

Filed May 11, 1916 Ruth McDonald Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 7 1916

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 17, 1916, to Mar 7 1916 that I last saw him alive on Mar 1 1916, and that death occurred on the date stated above, at 3A.M.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

(Duration) ..... yrs. ..... mos. nr ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Hawley M. D.

Mch 22 1916 (Address) McCall

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL ..... 191...

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. Meadows precinct

Primary Registration District No.

File No. 1485

County of Adams

City of Meadows (No. ....., ... St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julia Trumble Butler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May 13 1847 (Month) (Day) (Year)

7. AGE: 68 yrs. 11 mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Isaac Trumble

11. BIRTHPLACE OF FATHER (State or Country) Probably Ohio. unknown

12. MAIDEN NAME OF MOTHER — Keene

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. H. Butler
(Address) Meadows Idaho

15. Filed May 11 1916 Ruth McDonald Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24 1916, to May 2 1916 that I last saw h[illegible] alive on Apr 24 1916 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis
(Duration) 2 yrs. Probably mos. ds.
Contributory (Secondary) Grippe & pleurisy
(Duration) yrs. mos. 15 ds.
(Signed) F. S. Hawley M. D.
May 9 1916 (Address) Mackay

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. 15 yrs. ..... mos. ..... days. In the State 30 yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meadows Idaho — DATE OF BURIAL: May 8 1916

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & PORS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14286
Registered No. 9

1. PLACE OF DEATH. Registration District No. 62
County of Latah County Primary Registration District No. 2142
City of Genesee Ida. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thure Carlander

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: December 15 (Month) (Day) 1888 (Year)

7. AGE: 26 yrs. 7 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Carpenter
(b) General nature of industry business or establishment in which employed (or employer) H. F. Trimmer

9. BIRTHPLACE (State or Country) Minnesota

10. NAME OF FATHER Andrew Edward Carlander

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Josephine Skog.

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Andrew Edward Carlander
(Address) Moscow Ida.

15. Filed May 15 1916 O. W. Ekern Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1916, to May 12 1916
that I last saw h— alive on May 12 1916
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Fracture of Skull

..... (Duration) ..... yrs. ..... mos. 1 day ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. F. Thorny M. D.
May 13 1916 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Thorny Hospital ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho
DATE OF BURIAL: May 18 1916

20. UNDERTAKER: E. Lambert
ADDRESS: Genesee Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 62

Primary Registration District No. 2142

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14287

Registered No. 9

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. ~~Ward~~ PLACE OF DEATH.

County of Latah

City of Moscow

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Haakine Borgen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: September 15 (Month) (Day) 1878 (Year)

7. AGE: 37 yrs. 7 mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers Wife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Peders Olderson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Oline ~~Jorgensdatter~~ Hanson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gjemund Borgen
(Address) Moscow Idaho

15.
Filed May 7 1916 W. T. Kerr
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1916 to May 6 1916
that I last saw h.e alive on May 6 1916
and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(Duration) yrs. mos. 5 ds.

Contributory (Secondary) Appendicitis abscess

(Duration) 1 yrs. mos. ds.

(Signed) W. T. Kerr M. D.

May 7 1916 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lind Cem | DATE OF BURIAL: May 8 1916

20. UNDERTAKER: J. E. Lambert | ADDRESS: Genesee Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14288
Registered No. 10

1. PLACE OF DEATH.
County of Latah
City of Genesee (No. ....., ... St.)

Registration District No. 62
Primary Registration District No. 214

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Jefferey Nixon

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 2 (Day) 1900 (Year)

7. AGE: 16 yrs. 1 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Hey Perce Co Idaho

10. NAME OF FATHER: W A Nixon

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: May E Kelphrey

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W A Nixon
(Address) Genesee Ida

15. Filed May 21 1916 W H Keen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1916, to May 16 1916 that I last saw h alive on May 16 191 and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease
(Duration) ..... yrs. 15 mos. ..... ds.
Contributory (Secondary) Renal Rheumatism
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C F Drew M. D.
May 20 1916 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: May 22 1916

20. UNDERTAKER: H C Lambert — ADDRESS: Genesee Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 14289
Registered No. 33

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. 724 East 7th. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Patrick Kinnier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Irish

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. March 15th (Month) (Day) 1841 (Year)

7. AGE: 75 Yrs. 1 Mos. 16 ds.
IF LESS than 1 day how many .....hrs. or .....min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland Longford

10. NAME OF FATHER: John Kinnier

11. BIRTHPLACE OF FATHER (State or Country): Longford Ireland

12. MAIDEN NAME OF MOTHER: Catherine Farrell

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Kinnier
(Address) Moscow Ida

15. Filed May 6 1916 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-8-1915, to 5-4-1916, that I last saw h[illegible] alive on 5-3 1916, and that death occured on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:
Tabes Dorsalis

(Duration) 1 Yrs. [illegible] mos. [illegible] ds.
Contributory (Secondary) Chronic Interstitial Nephritis
(Duration ..... yrs. 4 mos. 0 ds.
(Signed) J. A. Dodd M. D.
5-6 1916. (Address) City.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: May 6 1916

20. UNDERTAKER: Glen Grice — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14290
Registered No. 38

1. PLACE OF DEATH.

Registration District No. 61
Primary Registration District No. 1011
County of Latah
City of Moscow
(No. Corner of Hayes & 3rd St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Grace Jane Sheldon.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May 16. (Month) (Day) 1883 (Year)

7. AGE 33 Yrs. Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER John C Baker

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Sarah J. Farr

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John C Baker

(Address) Moscow Idaho

15. Filed May 6 1916 L. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27-16 1916, to April 30 - 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 12:25 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Adenitis [redacted] disease
(Mitral Insufficiency)
(Duration) 5 Yrs. — mos. — ds.

Contributory (Secondary)
(Duration ... yrs ... mos ... ds.

(Signed) J. C. Wilson M. D.
May 5 1916. (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: May 6 1916

20. UNDERTAKER: Glen Price | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24953

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 14291
Registered No. 36

1. PLACE OF DEATH.

County of Latah
City of Moscow
(No. 415 East Third St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Wesley Linvalden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
June (Month) 29 (Day) 1862 (Year)

7. AGE
53 Yrs. 10 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Princeton Mercer County Mo

10. NAME OF FATHER
John Wesley Linvalden

11. BIRTHPLACE OF FATHER
(State or Country) Anderson Co. Tenn.

12. MAIDEN NAME OF MOTHER
Miss Juriah Harrymann

13. BIRTHPLACE OF MOTHER
(State or Country) Sullivan Co. Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. W. Linvalden Jr.
(Address) 415 East Third St.

15.
Filed May 6 1916
L. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3rd 1916, to May 3rd 1916, that I last saw him alive on May 3rd 1916, and that death occured on the date stated above, at 3:25 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) Ca. 15 min. Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) J. C. Wilk M. D.
May 4 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: May 6 1916

20. UNDERTAKER: Glen O Grice
ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14292
Registered No. 37

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. North Washington St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Hearn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH.
March (Month) 9 (Day) 1860 (Year)

7. AGE
56 Yrs. ..... Mos. 1 ds. 26
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

9. BIRTHPLACE
(State or Country) Ills

10. NAME OF FATHER Ephraim L. Stoner

11. BIRTHPLACE OF FATHER
(State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Sophia Earnest

13. BIRTHPLACE OF MOTHER
(State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm S Hunt
(Address) Moscow

15.
Filed May 6 1916
S. T. Poe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22 1916, to May 4 1916, that I last saw her alive on May 3 1916, and that death occured on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis

(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Abscess of Left Lung (Tuberculous)
(Duration ..... yrs. 6 mos. about ds.
(Signed) J. N. Clarke M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	May 7 1916

20. UNDERTAKER	ADDRESS
Glenn O'Neil	Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 61

Primary Registration District No. 1011

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14293

Registered No. 33

1. PLACE OF DEATH.

County of Latah

City of Moscow Ida (No. 845 East 8th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Louise DeWitt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April 23 (Month) (Day) 1841 (Year)

7. AGE: 69 Yrs. 1 Mos. 10 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Chillicothe Ross Co Ohio

10. NAME OF FATHER: Richard Bowdle

11. BIRTHPLACE OF FATHER (State or Country): Ross Co Ohio

12. MAIDEN NAME OF MOTHER: Sarah Bateman

13. BIRTHPLACE OF MOTHER (State or Country): Ross county Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) John W. DeWitt

15. Filed May 24 191 6

D F Rae
Local Registrar

STEIN - YORK CO., PTRS. & BKBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4th 1916, to May 3d 1916, that I last saw h[illegible] alive on May 3d 1916, and that death occured on the date stated above at 4:45 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma (Intestines)

(Duration) Yrs. 6 mos. 20 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Wilt M. D.

May 24 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: May 24 1916

20. UNDERTAKER: Glen Grice — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 14294
Registered No. 134

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julius Koch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 1st (Day) 1868 (Year)

7. AGE: Yrs. 47 Mos. 10 ds. 29
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Friederich Koch

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Wilhelmina Nee Mühlen

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Julius Koch
(Address) Moscow Idaho

15. Filed May 31 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11, 1916, to May 29 1916, that I last saw h alive on May 29 1916, and that death occured on the date stated above, at 11:45 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) 1 Yrs. 5 mos. ds.

Contributory (Secondary)

(Duration ... Yrs. ... mos. ... ds.

(Signed) J. C. Wirt M. D.
May 30 1916 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 5/31 1916

20. UNDERTAKER: Glen O Grice — ADDRESS: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14295

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth D. Oakes

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. Dec (Month) 9 (Day) 1860 (Year)

7. AGE: 55 Yrs. 5 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New Jersey

10. NAME OF FATHER: George Bloodt

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George C Weston

(Address) Emmett Idaho

15. Filed 6/3 1916

J. L. Haynes
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1916, to June 1 1916, that I last saw h[illegible] alive on May 31 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Thyroidism

(Duration) 20 Yrs. ..... mos. ..... ds.

Contributory (Secondary): Hemiplegia

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. O. Clark M. D.

19..... (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho

DATE OF BURIAL: 6/3 1916

20. UNDERTAKER: C. D. Beckham

ADDRESS: Emmett

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14296

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. 6

(No. ....., ... St.)

2. FULL NAME William Burgess

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Do not Know 1 (Month) (Day) (Year)

7. AGE: About 75 yrs ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. R. Coon.

(Address) Emmett Idaho

15. Filed 6/1 1916

J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 29 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1915, to April 29 1916, that I last saw h[illegible] alive on Last Week 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Valvular lesions of heart

not known by me (Duration) Yrs. ..... mos. ..... ds.

Contributory (Secondary) Bright's disease years (Duration) yrs. ..... mos. ..... ds.

(Signed) Alfred Skippen M. D.

19.... (Address) Sweet Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 6/1 1916

UNDERTAKER: C. D. Buckendorf — ADDRESS: Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14297

Registered No. .....

1. PLACE OF DEATH.

County of Boise

City of Gardena

Registration District No. .....

Primary Registration District No. 6

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lee Jesse McConnell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Jan (Month) 23 (Day) 1890 (Year)

7. AGE: 26 Yrs. 4 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Sheepgrower

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo W. McConnell

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary E. McConnell

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. W. McConnell

(Address) Emmett Idg

15.

Filed 5/10 1916

J. V. Ringenbach
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:

by gun shot wound

suicide

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Painter, Justice of the Peace acting Coroner.

..... 19..... (Address) Fruitland, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 5/10 1916

20. UNDERTAKER: C. D. Bucknum — ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Teton
City of Driggs (No. 0, St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 71
Primary Registration District No. 2169
File No. 14298
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stella Butler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April 30 1915 (Month) (Day) (Year)

7. AGE: yrs. 11 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Marion Wallace Butler

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ethel Eliza Jackson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Sadie Butler
(Address) Driggs, Ida.

15. Filed Apr. 21 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6 1916, to Apr 20 1916, that I last saw her alive on Apr 20 1916, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis

(Duration) yrs. mos. 2 6 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Chas J Martin M. D.
19 (Address) Driggs, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Driggs 1990 | DATE OF BURIAL: Apr 23 1916

20. UNDERTAKER [signature] | ADDRESS Driggs 1990

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14299

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Teton

City of Bates

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 77

Primary Registration District No. 2176

(No. ____, ____ St.)

2. FULL NAME Merritt Franklin Drake

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: February (Month) 9 (Day) 1887 (Year)

7. AGE: 29 yrs. 2 mos. 4 ds.

IF LESS than 1 day how many ____ hrs. or ____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Richard Drake

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Lovina Beecher

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isaac Drake

(Address) Bates, Idaho

15.

Filed Apr 14 1916

[signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 17 1916, to Apr 13, 1916, that I last saw him alive on Apr 13 1916, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 3 wks. mos. ds.

Contributory (Secondary) Fracture leg

(Duration) 4 wks mos. ds.

(Signed) Chas. H. Martin M. D.

19 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs ____ mos ____ days. In the State ____ yrs ____ mos ____ days.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Victor, Idaho

DATE OF BURIAL: Apr 15 - 1916

20. UNDERTAKER: T Moore

ADDRESS: ____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Teton
City of Driggs

Registration District No. 27
Primary Registration District No. 2-76
(No. ....., ... St.)

File No. 14300
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac Arbus Yielding

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Jan. (Month) 3 (Day) 1853 (Year)

7. AGE
63 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Alabama

10. NAME OF FATHER James Richard Yielding

11. BIRTHPLACE OF FATHER (State or Country) Ala.

12. MAIDEN NAME OF MOTHER Does not know

13. BIRTHPLACE OF MOTHER (State or Country) Died not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. I. A. Yielding
(Address) Victor Idaho

15.
Filed 4-10 1916 C. Cherrington
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 2 1916, to Apr 5 1916
that I last saw him alive on Apr. 3 1916
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia (Lobar)

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. J. Martin M. D.
19 (Address) Driggs, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Tetonia	Apr. 7 1916

20. UNDERTAKER None | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14301
Registered No.

1. PLACE OF DEATH
County of Teton
City of Dawson
(No. , St.)
Registration District No. 77
Primary Registration District No. 216
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Holcomb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: February (Month) 26 (Day) 1903 (Year)

7. AGE: 10 yrs. 10 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry business, or datablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Teton City Fremont Co Idaho

10. NAME OF FATHER: Thomas M Holcomb

11. BIRTHPLACE OF FATHER (State or Country): Parowan Iron Co Utah

12. MAIDEN NAME OF MOTHER: Harriet A Lamoreaux

13. BIRTHPLACE OF MOTHER (State or Country): Paragonah Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E A Killpack
(Address) Dawson Idaho

15. Filed 1-17-1916 M Kennedy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1916 to Jan 16 1916, that I last saw h in alive on Jan 14 1916, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis Meningitis

(Duration) yrs. mos. 14 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Chas J McCarty M. D.
Jan 17 1916 (Address) Driggs, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dawson Ida — DATE OF BURIAL: 1-18-1916

20. UNDERTAKER — ADDRESS: Driggs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2 77
Primary Registration District No. 2476
File No. 14302

1. PLACE OF DEATH.
County of Briggs
City of Leton
(No. ..... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lana, Edna, Morrison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 1 (Month) 20 (Day) 1861 (Year)

7. AGE: 55 Yrs. 4 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): South Charleston County Ohio

10. NAME OF FATHER: Edmund Price Hill

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Maryan Hunt

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John W. Stevens
(Address) Briggs Idaho

15. Filed 5-9 1916 C. Cherrington Local Registrar

SVMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-2 1916, to 5-8 1916, that I last saw her alive on 5-7 1916, and that death occured on the date stated above, at 11. a. M.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Gastric Ulcer.

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ben F. Newman M. D.

5-9 1916 (Address) Briggs, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Briggs Idaho
DATE OF BURIAL: 5-9 1916

20. UNDERTAKER: Herrington
ADDRESS: Briggs

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14303

Registered No. .....

Registration District No. 77

Primary Registration District No. 2176.

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Latah

City of Driggs

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur John Webster

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 5 (Month) 20 (Day) 1916 (Year)

7. AGE: .....Yrs. .....Mos. 4 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Driggs Idaho

10. NAME OF FATHER: W. A. Webster

11. BIRTHPLACE OF FATHER (State or Country): Grant Idaho

12. MAIDEN NAME OF MOTHER: Rose Reynolds

13. BIRTHPLACE OF MOTHER (State or Country): Castle Dale Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Reynolds

(Address) Driggs Idaho

15. Filed May 25 1916 E. E. Newman Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-20 1916, to 5-24 1916, that I last saw him alive on 5-24- 1916 and that death occured on the date stated above, at 1030 a M.

The CAUSE OF DEATH* was as follows:

Icterus Neonatorum

.....(Duration) .....Yrs. .....mos. 4 ds.

Contributory (Secondary)

.....(Duration .....yrs. .....mos. .....ds.

(Signed) Ben F. Roseman M. D.

5-24 1916 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grant Idaho — DATE OF BURIAL: 5-26 1916

20. UNDERTAKER: E. E. Newman — ADDRESS: Driggs

CERTIFICATE OF DEATH

State of Utah
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Tooele
City of Mustang (No. ..... St.)
Registration District No. 36
Primary Registration District No. .....
File No. 14309
Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Primrose Shields Lee

If death occurred in hospital, institution, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

DATE OF BIRTH. July (Month) 7 (Day) 1842 (Year)

AGE: 73 Yrs. 5 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

BIRTHPLACE (State or Country): Scotland

NAME OF FATHER: John Shields

BIRTHPLACE OF FATHER (State or Country): Scotland

MAIDEN NAME OF MOTHER: Primrose Cunningham

BIRTHPLACE OF MOTHER (State or Country): Scotland

I HEREBY CERTIFY THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John S. Lee

(Address) Tooele Utah

Filed May 31 1916 J M Davis Local Registrar

YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 3 (Day)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1915, to Dec 15 that I last saw her alive on Dec 15 and that death occured on the date stated above, at

The CAUSE OF DEATH* was as follows:
Bronchitis following Lagrippe and Senility

(Duration) ..... Yrs. One mos.

Contributory (Secondary): Lagrippe

(Duration ..... yrs. ..... mos.

(Signed) Dr M Veit

Jan 3 1916 (Address) Mustang

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Tooele Utah. DATE: Jan 5

20. UNDERTAKER: L B Golloghy ADDRESS: Burial

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Lapwai -
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 97
Primary Registration District No. 2174
(No. Fort Lapwai Indian Town St.)

File No. 14306
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ernest Carpenter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	Indian	Single

6. DATE OF BIRTH
(Month) (Day) (Year) 1899

7. AGE 17 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Student.
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) B. C.

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) not Known

12. MAIDEN NAME OF MOTHER not Known

13. BIRTHPLACE OF MOTHER (State or Country) not Known.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fort Lapwai Allotment Records
(Address) Lapwai Idaho.

15. Filed May 5 1916 William P. Hoff
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
(Month) May (Day) 5 (Year) 1916

17. I HEREBY CERTIFY, That I attended deceased from March 4 1916, to May 5 1916, that I last saw him alive on May 5 1916, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis.

(Duration) yrs. 2 mos. — ds.

Contributory (Secondary) General Tuberculosis.

(Duration) yrs. — mos. — ds.

(Signed) William P. Hoff M. D.
5/5 1916 (Address) Lapwai -

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 4 mos. 3 days. In the State ..... yrs. 4 mos. 3 days.
Where was disease contracted if not at place of death? Salt Spring - B. C.
Former or usual residence Tacoma - Washington

19. PLACE OF BURIAL OR REMOVAL Tacoma Wash. | DATE OF BURIAL 5-7 1916

20. UNDERTAKER Mann & Mann. | ADDRESS Lapwai.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bucevah

City of St Maries

Registration District No. 93

Primary Registration District No. 2049

(No. ....., ... St.)

File No. 14307

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hollis C. Anglin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 29 (Day) 1887 (Year)

7. AGE: 28 Yrs. 10 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): Lumbering. Woodman.

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Wm A. Anglin.

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Louisa —

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Zigler.

(Address) St Maries

15.

Filed May 10 1916

H E H, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1916, to May 8 1916, that I last saw him alive on May 7 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Lymphatic Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pott Disease

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Kinnebrew M. D.

May 9 1916, (Address) St Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Waynetown Ind.

DATE OF BURIAL: ..... 191...

20. UNDERTAKER: H E Hunt

ADDRESS: St Maries

SYMS - YORK CO., PTG. & BOOK. 24654

N. B.—Every item of information should be carefully supplied. Age should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14308

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 32

Primary Registration District No. 2a 1/9

County of Bonneville

City of St Maries (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Lichti

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dont know — (Month) (Day) (Year)

7. AGE: About 25 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Loggin
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Dont know

11. BIRTHPLACE OF FATHER (State or Country): Dont know —

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W H Riggles
(Address) St Maries

15. Filed May 12 1916 H E Hunt, Local Registrar

SYMS - YORK CO., PTRS. Boise. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1916, to May 11 1916, that I last saw him alive on May 10 1916 and that death occured on the date stated above, at 5-10 M.

The CAUSE OF DEATH* was as follows:
Chronic Disease of Kidneys with Dropsy (Bright's Disease)
(Duration) Several years
Contributory (Secondary) Dont know —
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C H Kinsolving M. D.
5/12 1916, (Address) St Maries, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: May 12 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14309

Registered No. .....

1. PLACE OF DEATH.

County of Bennewah

City of St maries Ida

Registration District No. 92

Primary Registration District No. 2049

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ann Jennette Shaw

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. October (Month) 13th (Day) 1833 (Year)

7. AGE: 82 Yrs. 7 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Near Rochester New York

10. NAME OF FATHER John Post

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Root

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian Shaw Clark

(Address) St. Maries Idaho

15.

Filed May 31 1916

H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1916, to May 30 1916, that I last saw her alive on May 30 1916, and that death occured on the date stated above, at 4 30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis & Bronchitis

.....(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Nephritis

.....(Duration) ..... yrs. ..... mos. ..... ds.

5/31 1916 (Signed) L E Cornwall M. D.

(Address) St maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bloomington Ill. | DATE OF BURIAL .....191.....

20. UNDERTAKER: H E Hunt | ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOOKS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14310

Registered No.

1. PLACE OF DEATH.

County of Bear Lake

City of Fish Haven

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 55

Primary Registration District No.

(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Bellis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: girl

4. COLOR OR RACE: ~~White~~ English

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: May 18th 1895 (Month) (Day) (Year)

7. AGE: 19 yrs. 11 mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: General Housemaid
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Wales.

10. NAME OF FATHER: Wm Bellis

11. BIRTHPLACE OF FATHER (State or Country): Wales. Eng.

12. MAIDEN NAME OF MOTHER: Amelia Thompson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs T. Hartney
(Address) Fish Haven

15.
Filed May 20 1916 John Matteson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 16 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1916, to May 16 1916, that I last saw h~~e~~er alive on May 16 1916, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Cystitis

(Duration) 2 yrs. mos. ds.

Contributory (Secondary) Streptococcus Pyogenes

(Duration) yrs. mos. ds.

(Signed) Geo F Cooley M. D.

May 17 1916 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fish Haven Ida — DATE OF BURIAL: May 19 1916

20. UNDERTAKER: H. Shirley — ADDRESS: Fish Haven Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
File No. 14311
Registered No.

1. PLACE OF DEATH.
County of Latah
~~City~~ of near Troy
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth M Bricker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: April (Month) 29 (Day) 1909 (Year)

7. AGE: 7 yrs. 1 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Char H Bricker

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Emma Mirick

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph Bricker
(Address) Garfield Wash R.3

15.
Filed June 3 1916
D. J. W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1916, to June 2 1916, that I last saw her alive on May 31 1916. and that death occurred on the date stated above, at 7.45 P M.

The CAUSE OF DEATH* was as follows:

Spinal Meningitis

(Duration) ..... yrs. 1 mos. ..... ds.

Contributory (Secondary) Valvular heart disease.

(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) Geo T Boyd M. D.

June 3 1916. (Address) Palouse Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Greenleaf Forest	June 4 1916

20. UNDERTAKER	ADDRESS
E Anderson	Palouse

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Potlatch (vicinity)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65
Primary Registration District No. 2145
(No. ..... St.)

File No. 14312
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella C Grant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: Oct (Month) 11 (Day) 1852 (Year)

7. AGE: 63 yrs. 6 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Grant
(Address) Palouse Wn

15.
Filed May 7th 1916 D. J. M. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1916 to May 6 1916
that I last saw her alive on May 6 1916
and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.
Contributory (Secondary) Tuberculosis Pulmonary
(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) D B Hartman M. D.
5/6 1916. (Address) Palouse

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fuers Cemetery
DATE OF BURIAL: May 8th 1916

20. UNDERTAKER: E. Anderson
ADDRESS: Palouse Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2007

File No. 14313

County of Canyon

City of Parma (No. ....., ... St.)

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Gilbert Eversen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
W	W	Sing

6. DATE OF BIRTH: May 25 1916 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canyon Co Ida

10. NAME OF FATHER Tyler Eversen

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Ethel Glover

13. BIRTHPLACE OF MOTHER (State or Country) Okla

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tyler Eversen
(Address) Parma

15. Filed May 28 1916 Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1916 to May 27 1916 that I last saw him alive on May 27 1916 and that death occurred on the date stated above, at 9:30 M.

The CAUSE OF DEATH* was as follows:
Convulsions due to injury during labor

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) Instrumental delivery

(Duration) — yrs. — mos. — ds.

(Signed) William E. Waldrop M. D.

May 28 1916 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Nyssa Ore. DATE OF BURIAL: May 28 1916

20. UNDERTAKER: Peckham Case Co ADDRESS: Parma

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2007

File No. 14314

City of Parma (No. ....., ... St.)

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Agnes Dickerson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	widow

6. DATE OF BIRTH: Sept (Month) 2 (Day) 1849 (Year)

7. AGE: 67 yrs. 8 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Hilton

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Vasbinder

13. BIRTHPLACE OF MOTHER (State or Country): Do not Kno

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Dickerson
(Address) Parma

15. Filed May 12 1916 Lulu Waldo Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH (W.B.W.) May 10 - 1916
~~April 5~~ ~~5~~ 191
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5" 1916, to May 10" 1916, that I last saw her alive on May 10 1916, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(Duration) 2 yrs. 3 mos. — ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. mos. 14 ds.

(Signed) W. B. Muldoon M. D.
May 13 1916 (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parma — DATE OF BURIAL: May 12 1916

20. UNDERTAKER: Cockham Lewis & Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENRS. 19760

FORM V. S. No. 5-25 M. 1-16-13 No. 5

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31

Primary Registration District No.

File No. 14315

Registered No.

1. PLACE OF DEATH.

County of Bonneville

City of Coeur d'Alene Reserv Dismel

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Arippa

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. September 17 1906 (Month) (Day) (Year)

7. AGE 9 Yrs. 8 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Coeur D'Alene Reserv. Co- Bonneville

10. NAME OF FATHER Stanislaus Arippa

11. BIRTHPLACE OF FATHER (State or Country) Coeur D'Alene Reservation

12. MAIDEN NAME OF MOTHER Mary

13. BIRTHPLACE OF MOTHER (State or Country) Spokane Reserv. Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanislaus Arippa Father

(Address) Coeur d'Alene Reserv. Idaho Dismel, Idaho

15. Filed May 24th 1916 John Post Asst. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 23rd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 1916, to May 23rd 1916, that I last saw him alive on May 23rd 1916, and that death occured on the date stated above, at 6.30 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary) Pulmonary Hemorrhage

(Duration — yrs. — mos. — ds.

(Signed) Eugene W. Hill M. D.

5/24 1916 (Address) Dismel-Ida. U.S.I.S.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~ Dismel. Idaho — **DATE OF BURIAL** May 24 1916

20. UNDERTAKER John Post — **ADDRESS** Dismel, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

County of ....Weber.....

City of ....Ogden.....

Primary Registration District No. 2176

(No. ....., ... St.)

Bureau of Vital ...

File No. ...14316...

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME. Arthur John Webster

If death occurred in a hospital institution or camp, give its NAME instead of street and number.

The information on this certificate is an exact COPY of the official certificate filed at place of death.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. Single, Married, Widowed or Divorced. (Write the Word): Single

6. DATE OF BIRTH. ...5.....20.....1916.
(Month) (Day) (Year)

7. AGE: .....Yrs .....Mos ....ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ogden

10. NAME OF FATHER: W. A. Webster

11. BIRTHPLACE OF FATHER (State or Country): Grant

12. MAIDEN NAME OF MOTHER: Rose A. Reynolds

13. BIRTHPLACE OF MOTHER (State or Country): Castle Dale Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X Francis A. Reynolds
(Address).....

15. Filed ...May 25...191.6. ...Local Registrar.

Place Where Remains are to be Sent: Grant Utah

Date of Shipment: 5.26.191.6.

SHIPPING UNDERTAKER

ADDRESS ....Ogden.... Firm Name.....

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH.
.....5.....24..... 191...
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
.....5.20.....1916, to ..5.24.....1916
that I last saw him alive on .....5.24.....1916
and that death occured on the date stated above, at .....M

The CAUSE OF DEATH was as follows:
....Cerebro Hemorrhage.....
.....
.....
.....(Duration) .....Years .....mos.. ..ds

Contributory (Secondary) .....

.....(Duration) .....Years.....mos.....ds

(Signed) B. H. Rossman M. D
5.24.1916. (Address) Ogden

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)
At place of death....yrs....mos....days
In the State ....yrs...mos...days

Where was disease contracted if not at place of death .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grant

Date of Burial: ...5.26.1916

20. UNDERTAKER: A. Monson Co.

Address: Ogden

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 4437
Registered No.

1. PLACE OF DEATH.
County of Bannock
City of Bancroft
(No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Gilbert Adams
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Jan (Month) 19 (Day) 916 (Year)

7. AGE: yrs. 3 mos. 12 ds.
IF LESS than 1 day how many? ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jan Adams

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Lucy Kirby

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Jan Adams
(Address): Bancroft Ida

15. Filed 5/13 1916 Dr W J Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 3/ (Day) 1916 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ 191~~...~~ to ... 191 ... ~~that I last saw him alive on~~ ... 191 ..., and ~~that~~ death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Broncho
pneumonia
(Duration) ... yrs. ... mos. 3 ds.
Contributory (Secondary) Pertussis
(Duration) ... yrs. 1 mos. 21 ds.

(Signed) W J Smith M. D.
5/13 1916 (Address) Bancroft

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Turner Ida
DATE OF BURIAL: May 2 1916

20. UNDERTAKER: none
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14318

Registered No. ____

Registration District No. 20

Primary Registration District No. 2012

(No. ____, ____ St.)

1. PLACE OF DEATH.

County of Teton

City of Victor

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma C. Chisman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. November 29 1856
(Month) (Day) (Year)

7. AGE: 59 Yrs. 6 Mos. 12 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Iowa. Monroe County

10. NAME OF FATHER: David Forsyth

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Margaret Haugh

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. P. Chisman
(Address) Victor Idaho.

15. Filed 5/13/16 191__ L. D. Chadwick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 12th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28 1916, to May 12 1916, that I last saw her alive on May 12 1916, and that death occured on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Uremia & Coma

(Duration) ____ Yrs. ____ mos. 14 ds.

Contributory (Secondary) pneumonia

(Duration ____ yrs. ____ mos. 1 ds.

(Signed) Louis Vitzin M. D.

May 19 16 (Address) Victor Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 6 mos. ____ days. In the State 1 yrs. 8 mos. ____ days

Where was disease contracted if not at place of death? at Victor

Former or usual residence Monroe County Iowa

19. PLACE OF BURIAL OR REMOVAL: Oregon Iowa — DATE OF BURIAL 191 6

20. UNDERTAKER: McCorkle — ADDRESS Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Gifford Nez Perce
City of Gifford
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 902
Primary Registration District No. 2170
(No. ....., ... St.)

File No. 14319
Registered No. 6
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hugh Atwood Porter

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May - 10th - 1916,
(Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many 10 hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Gifford Idaho,

10. NAME OF FATHER: Herald Porter,

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Thelma Alice Comwall,

13. BIRTHPLACE OF MOTHER (State or Country): Oregon,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [redacted] Porter.
(Address) Gifford Idaho.

15. Filed 5 - 10 1916 E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May - 10th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10th 7 A.M. 1916., to May 10th to 5 P.M. 1916, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Livingstone M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gifford Ida
DATE OF BURIAL: 5 - 11 1916

20. UNDERTAKER: W. E. Stoddard
ADDRESS: Gifford Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Kendrick
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No. 2143
(No. ....., ... St.)

File No. 14320
Registered No. 29
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emily Jane Powell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 8 (Day) 1855 (Year)

7. AGE: 61 yrs. 3 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Nance

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C Powell husband
(Address) Kendrick Ida

15. Filed May 15 1916 J E Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1916, to May 14 1916, that I last saw h[illegible] alive on May 14 1916, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Diabetic Coma

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Diabetes
(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) J E Hoyt M. D.
May 14 1916 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kendrick Cemetery
DATE OF BURIAL: May 16 1916

20. UNDERTAKER: E E Bechtol
ADDRESS: Kendrick Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Kendrick (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No. 7143

File No. 14321
Registered No. 28
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Millie Looney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Widow

6. DATE OF BIRTH: Feb (Month) 2 (Day) 1840 (Year)

7. AGE: 76 yrs. 3 mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Wm Rutherford

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Flora Pricket

13. BIRTHPLACE OF MOTHER (State or Country): Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Flora Meyers
(Address) Kendrick Ida Douglas

15. Filed May 7 1916 J. E. Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1916, to May 1st 1916, that I last saw h[illegible] alive on May 1st 1916, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory —
(Secondary)

(Duration) — yrs. ..... mos. ..... ds.

(Signed) J. E. Hoyt M. D.
May 7 1916 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cedar Creek Cemetery	May 3 1916

20. UNDERTAKER	ADDRESS
E. E. Bechtal	Kendrick

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS – YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Kendrick
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No. 2143
(No. ....., ... St.)

File No. 14322
Registered No. 30
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary R Babcock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
F	W	Married

6. DATE OF BIRTH: Sep (Month) 29 (Day) 1888 (Year)

7. AGE: 28 yrs. 6 mos. — ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: David Melleville

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Jane Galloway

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wilhelmina Melleville
(Address) Kendrick Ida

15. Filed May 29 1916 J E Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1910, to May 28 1916, that I last saw h[illegible] alive on May 23 1916, and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Acute dilatation of heart
Sudden death
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Valvular disease of heart
..... (Duration) 15 yrs. ..... mos. ..... ds.

(Signed) J. E. Hoyt M. D.
May 29 1916 (Address) J E Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Bear Ridge Cemetery — DATE OF BURIAL: May 30 1916

20. UNDERTAKER: E E Bechtol — ADDRESS: Kendrick Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. [illegible] CERTIFICATE OF DEATH [illegible]

Place of Death — Registration District No. 3 — Bureau of Vital Statistics

County of Fergus — Primary Registration District No. 214 — File No. 14325

City of Ho. (No. ....., ... St.) — Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Naomie Ray Hobart

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: December (Month) 9 (Day) 1902 (Year)

7. AGE: 13 yrs. 5 mos. 19 ds.

IF LESS than 1 day how many ..... hr. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Neptune R. 4 D.

10. NAME OF FATHER: James L. Hobart

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Elizabeth Crumpacker

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James L. Hobart
(Address) Neptune R 4 D

15.
Filed 5/30 1916 — P. E. Dunlap — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26 1916, to May 28 1916
that I last saw her alive on May 27 1916
and that death occurred on the date stated above, at 10¼ M.

The CAUSE OF DEATH* was as follows:
Pernicious anaemia

Contributory (Duration) 2 yrs. mos. ds.

Contributory (Secondary) Mutual Reserve Life

(Duration) 7 yrs. mos. ds.

(Signed) P. E. Dunlap M. D.
5/30 1916 (Address) Ho, Mont.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I O O F Cemetery — DATE OF BURIAL: 5/30 1916

20. UNDERTAKER: H. C. Stoddard — ADDRESS: Gilford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exament of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14324

Registered No. 7

1. PLACE OF DEATH.

County of Lewis

City of Ilo

Registration District No. 60

Primary Registration District No. 2129

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vena Daniels

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: full blood Nez Perce Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 21 Yrs. 22 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Juliaetta Idaho

10. NAME OF FATHER: Mike Eneas

11. BIRTHPLACE OF FATHER (State or Country): Lawiston Idaho

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Boell

(Address) Ilo, Idaho

15. Filed May 9 1916 R E Dunlap Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1916, to May 9 1916, that I last saw h[illegible] alive on May 5 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ..... Yrs. 4 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R E Dunlap M. D.

5/9 1916 (Address) Ilo, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jones Water Alice Idaho — DATE OF BURIAL: 5/11 1916

20. UNDERTAKER: Thomas Boell — ADDRESS: Ilo, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SQRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 116
Primary Registration District No. 2150
(No. ....., ... St.)

File No. 14325
Registered No. 40
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Dirks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
March 27 1915
(Month) (Day) (Year)

7. AGE
1 yrs. 1 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Leonhard Dirks

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Minna Bartel

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L Dirks
(Address) Aberdeen

15.
Filed May 9 1916 M. C. MacKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 9 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1916, to May 9 1916 that I last saw him alive on May 9 1916 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Measles,

(Duration) ..... yrs. ..... mos. 9 ds.
Contributory (Secondary) Meningitis.
(Duration) — yrs. — mos. 2 ds.

(Signed) M. C. MacKinnon M. D.
May 9 1916 (Address) Aberdeen, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Memmento Cemy	May 11 1916
20. UNDERTAKER L Dirks Actg	ADDRESS Aberdeen Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of ~~Bingham~~
City of American Falls.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 116
Primary Registration District No. 2195
(No. ....., ... St.)

File No. 14326
Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Herman Wiens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Sept (Month) 16 (Day) 1910 (Year)
7. AGE: 5 Yrs. 7 Mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Boy at home
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): American Falls Idaho
10. NAME OF FATHER: D. J. Wiens
11. BIRTHPLACE OF FATHER (State or Country): Nebraska
12. MAIDEN NAME OF MOTHER: Mary Friesen
13. BIRTHPLACE OF MOTHER (State or Country): Minnesota
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. J. Wiens
(Address)
15. Filed May 2 1916 M. Cunningham Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 1st (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw h— alive on — 191..., and that death occured on the date stated above, at —M.
The CAUSE OF DEATH* was as follows:
Died was dead when I arrived
Had died from means probably
Complicated with Pneumonia
— (Duration) — Yrs. — mos. 6 ds.
Contributory (Secondary): None
..... (Duration — yrs. — mos. — ds.
(Signed) O. F. Starr M. D.
May 2. 1916 (Address) American Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Cemetery - Aberdeen

19. PLACE OF BURIAL OR REMOVAL: ~~Cemetery~~ D. J. Wiens — DATE OF BURIAL: May 4 1916
20. UNDERTAKER: Cemetery D. J. Wiens — ADDRESS: American Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14327

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Minidoka

City of Burley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18

Primary Registration District No. 2102

(No. ....., ... St.)

2. FULL NAME Baby Hjorth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word): Single

6. DATE OF BIRTH. Mar (Month) 10 (Day) 1916 (Year)

7. AGE ——— Yrs. 1 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Infant

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Minidoka County

10. NAME OF FATHER A A Hjorth

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Charlotte Neibaur

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) I Neibaur

(Address) Heyburn

15. Filed May 10 1916 V. P. Kilburn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) — 20 (Day) — 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/18 — 1916, to 4/20 — 1916, that I last saw h[illegible] alive on 4/19 — 1916, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

— (Duration) — Yrs. — mos. 7 ds.

Contributory (Secondary) n na.

— (Duration — yrs. — mos. — ds.

(Signed) G H Cooper — M. D.

19..... (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Heyburn Ida — DATE OF BURIAL: 4/23 1916

20. UNDERTAKER: Watt Furniture Co — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. (1000) 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 18
Primary Registration District No. 2102
File No. 14328
Registered No. 6

1. PLACE OF DEATH.
County of Minidoka
City of Heyburn
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elizabeth Kimmerling

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH.
Jan (Month) 18 (Day) 1847 (Year)

7. AGE
69 Yrs. 2 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Shelby Co. Ohio.

10. NAME OF FATHER: John F. Burck.

11. BIRTHPLACE OF FATHER
(State or Country) Ohio.

12. MAIDEN NAME OF MOTHER: Margrete Bower.

13. BIRTHPLACE OF MOTHER
(State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. E. Kimmerling
(Address) Heyburn Ida

15. Filed May 10 1916 V. P. Kilburn Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 2nd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st 1915, to April 2nd 1916, that I last saw her alive on April 1st 1916, and that death occured on the date stated above, at 8a. M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Trouble.

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Cystitis

(Duration 40 yrs. ..... mos. ..... ds.
(Signed) J. V. Patterson M. D.
4-3 1916. (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Heyburn Ida.	April 5 1916
20. UNDERTAKER	ADDRESS
L. B. Talloffy.	Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14330

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of Twin Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

2. FULL NAME Chesley Stuart Woodward

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 7 (Day) 1914 (Year)

7. AGE: 1 Yrs. 5 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Twin Falls Ida.

10. NAME OF FATHER: John S. Woodward,

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Lillian Puckett

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. S. Woodward.

(Address) Twin Falls Ida 611 East 3rd

15. Filed 3-1 1916 John W. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/25/1916, to 3/1/1916, that I last saw him alive on 3/1/1916, and that death occured on the date stated above, at 12-59 M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Pike M. D.

3/1/1916 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: March 2 1916

20. UNDERTAKER: Grossman & Kruse ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STERN - VOSBURGH PTG. & ENGR. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 1085

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14331

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of .....

(No. ....., ..., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Virginia Vera

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. (X) Sept 9th (Month) (Day) 1911 (Year)

7. AGE: 4 Yrs. 5 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Buhl Idaho

10. NAME OF FATHER P. W. Vera

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Ethel Jarvis

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. W. Vera

(Address) 442-5th Ave East Twin Falls Ida

15.

Filed 2-5 1916 J. H. Coughlan Local Registrar

BYNS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feby 4 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Feby 4 1916, that I last saw h.. alive on Feby 4 1916, and that death occured on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart.

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Mitral Regurgitation

(Duration ..... yrs. 4 mos. 2 2 ds.

(Signed) D. Mcam D.H. Strandw M. D.

Feb 6 1916 (Address) 116½ Main St N

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Feb 6 1916

20. UNDERTAKER: C J Crosby — ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

Boyd

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1055
File No. 14332
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margarite Anna Bamberry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June 8th 1914 (Month) (Day) (Year)

7. AGE: 1 Yrs. 9 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER David Bamberry

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Margarite Joseph

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David Bamberry
(Address) Twin Falls R.F.D. #2

15.
Filed 4-7 1916
J. F. Coulter
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
4-1 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29 1916, to April 4th 1916, that I last saw her alive on April 4th 1916, and that death occured on the date stated above, at 11 30 P.M.

The CAUSE OF DEATH* was as follows:
Stomach Poisoning

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. 10 ds.

(Signed) D.O. Boyd M. D.

.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 4-7 1916

20. UNDERTAKER: C. J. Crosby
ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14333

Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of "" (No. ....., ... St.)
Registration District No. 37
Primary Registration District No. 1095
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carlos Orville Blade

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) [illegible]

6. DATE OF BIRTH. Jan 31st (Month) (Day) 1916 (Year)

7. AGE: ..... Yrs. 1 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Twin Falls

10. NAME OF FATHER Orville Blade

11. BIRTHPLACE OF FATHER (State or Country) Neb

12. MAIDEN NAME OF MOTHER Pearl Nace

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Orval Blade
(Address) Twin Falls

15. Filed 3-9 196 J. McLaughlen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 8 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26th 1916, to March 8 1916, that I last saw h[illegible] alive on March 6 1916, and that death occured on the date stated above, at 2-25 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 30 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Duncan K Stewart M. D.

3/8 1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls — DATE OF BURIAL 3-9 1916

20. UNDERTAKER C J Crosby — ADDRESS Twin Falls

SYMS - YORK CO., PTRS. & SOHS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 14334
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Katie Pifer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced
6. DATE OF BIRTH. About ..... (Month) ..... (Day) 1 (Year)
7. AGE: 57 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Traveling Saleslady
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Ill.
10. NAME OF FATHER: Mac Kenzie
11. BIRTHPLACE OF FATHER (State or Country): Unknown Suppose to Scotland
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. H. Pifer
(Address) Washington Wash
15. Filed 2-28 1916 John F. Gaughen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 23 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 2/20/1916, to 2/23/1916, that I last saw her alive on 2/23/1916, and that death occured on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Acute Bronchitis
(Duration ..... yrs. ..... mos. 14 ds.
(Signed) W. G. Pike M. D.
2/27/1916 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Removal

19. PLACE OF ~~BURIAL OR REMOVAL~~: Wallsburg Wash. DATE OF BURIAL: 2- 1916
20. UNDERTAKER: O J Crosby ADDRESS: Twin Falls

6198 - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 35
Primary Registration District No. 1085
File No. 14335
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls Ida.
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter Kennedy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec. (Month) 1 (Day) 1872 (Year)

7. AGE: 43 Yrs. 3 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kan.

10. NAME OF FATHER: Jefferson Kennedy

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Elizabeth Franklin

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Kennedy
(Address) Hansen, Idaho

15. Filed Mar 31 1916
John F Cowley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 30th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 10-30 P. M.

The CAUSE OF DEATH* was as follows:
Suicide. Fall from
O.S.L. Railroad Bridge
(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....
(Duration ... Yrs. ... mos. ... ds.

(Signed) Chas. E. Crosby M. D.
19... (Address) Twin Falls Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 4-1 1916

20. UNDERTAKER: Goodman & Evans.
ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1065
File No. 14336
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls, (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Lenard Hoover

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March 10th 1893 (Month) (Day) (Year)

7. AGE: 23 Yrs. 0 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): [redacted]

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: J. Lenard

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Mary Lenox

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ed M Hoover
(Address) Twin Falls

15. Filed 4-1 1916 J Douglas Local Registrar

SYMS - YORK CO., PTRS. & SOLS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 29th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6th 1916, to March 29th 1916, that I last saw her alive on March 29th 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Anemia

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) Acute Bright's Disease

(Duration ..... yrs. 1 mos. ..... ds.

(Signed) Duncan L Maxwell M. D.

March 29/1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls. DATE OF BURIAL: 4-1 1916

20. UNDERTAKER: Swanson & Evans ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14337

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of .....

Registration District No. 37

Primary Registration District No. 1085

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm W Smith

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. October (Month) ..... (Day) 1885 (Year)

7. AGE: 30 Yrs. 5 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER Thos. Smith

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Elizabeth Shamel

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J A Smith
(Address) Rogerson Idaho

15. Filed Mar 29 1916 John T Coughlin Local Registrar

SYMS - YORK CO., PTRS. & ROBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 27 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Suicide by gunshot

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos ..... ds.

(Signed) Charles J Crosby M. D.
Coroner
19..... (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 3-27 1916

20. UNDERTAKER: C. J. Crosby
ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls

City of ( )

Registration District No. 37

Primary Registration District No. 1085

(No. ....., ... St.)

File No. 14338

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maggie Edwards

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. (Month) 3 (Day) 1872 (Year)

7. AGE: 43 Yrs. 5 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Christopher Fridl

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Katherine Stear

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. E. Edwards
(Address) Twin Falls

15. Filed 3-27 1916 John T. Taylor Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3-26 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1916, to March 26 1916, that I last saw her alive on March 26 1916, and that death occured on the date stated above, at 12-10 M.

The CAUSE OF DEATH* was as follows:

General Anasarca

.....(Duration) ..... Yrs. One mos. ..... ds.

Contributory (Secondary) Pyelonic Obstruction (Cancerous)

.....(Duration ..... yrs. 8 mos. ..... ds.

(Signed) E O Wyeth M. D.

3-27 1916 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Mar. 28 1916

20. UNDERTAKER: Emmanuel Ennes — ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1055
File No. 14339
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lee L. Annis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: March 3rd 1894
(Month) (Day) (Year)
7. AGE: 22 Yrs. ..... Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Oklahoma
10. NAME OF FATHER: L. P. Annis
11. BIRTHPLACE OF FATHER (State or Country): Ga
12. MAIDEN NAME OF MOTHER: Mary E. Miller
13. BIRTHPLACE OF MOTHER (State or Country): Ga
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. P. Annis
(Address) Twin Falls
15.
Filed 3-20 1916
J. H. Cayler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 19 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 1.45 P. M.

The CAUSE OF DEATH* was as follows:
Fell from Railroad bridge just west of Twin Falls, Accidental
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs ..... mos ..... ds.
(Signed) Chas. J. Crosby M. D.
19... (Address) Twin Falls Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 3-20 1916
20. UNDERTAKER: C. J. Crosby
ADDRESS: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

6YMS - YORK CO., PTRS. & SDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1095
File No. 14340
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Lee Hodges

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec 24th (Month) (Day) 1909 (Year)

7. AGE: 6 Yrs. 2 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School girl
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mo

10. NAME OF FATHER J. S. Hodges

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Francis Holbert

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. L. Hodges
(Address) R. Rt. Twin

15.
Filed 3-10 1916
J. H. Caughlan
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8 1916, to March 8 1916, that I last saw her alive on March 8 1916, and that death occured on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:
Asphyxia

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Anaesthetic Ether Narcosis
.....(Duration ..... yrs. ..... mos. / ds.
(Signed) John R Morgan M. D.
3-10-1916. (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 3-10 1916

20. UNDERTAKER: J. Crosby — ADDRESS: T. F.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14341
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo Henry Rasgell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Dec 16 (Month) (Day) 1847 (Year)

7. AGE: 74 Yrs. 3 Mos. 0 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wesley Rasgell

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Nancy Carson

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H Rasgell
(Address) Twin Falls, Ida

15. Filed 3-19 1916 J. H. Congleton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 20 1915, to Mar 17 1916, that I last saw h in alive on Mar. 15 1916, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
senile dementia
.....
.....
.....(Duration) 5 or 6 years Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Weaver M. D.
19..... (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 3-19 1916

20. UNDERTAKER: Chas J Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1055
File No. 14342
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ada Fraker

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug 6th 1891
(Month) (Day) (Year)

7. AGE: 24 Yrs. 6 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: H.C. Fraker

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Nettie Mitchell

13. BIRTHPLACE OF MOTHER (State or Country): Cala

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lloyd N. Reynolds
(Address) Rogerson Ida

15.
Filed 4-6 1916
J. H. Caughlan
Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr 4th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on Unknown 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Found dead in Rock Creek Canyon
Apr 6th Suppose cause of death
Suicide by Morphine
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. J. Crosby M. D.
19..... (Address) Twin Falls Oregon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 4-9 1916

20. UNDERTAKER: C J Crosby — ADDRESS: T Falls

FORM V. S. No. 5-25 M. 1-16-13

Morgan

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1055
File No. 14343
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Anna Odella Ahern

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept 10 (Month) (Day) 1884 (Year)

7. AGE: 31 Yrs. 6 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Casper

11. BIRTHPLACE OF FATHER (State or Country): New York ~~Germany~~

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ed Ahern
(Address) Twin Falls

15.
Filed 4-5 1916
J. E. Eglin
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 3rd (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31 1916, to April 3 1916, that I last saw h alive on April 3 1916, and that death occured on the date stated above, at 1.58 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Hemorrhage of brain
..... (Duration ..... yrs. ..... mos. 3 ds.
(Signed) John R. Morgan M. D.
4-3 1916 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 4-5 1916

20. UNDERTAKER: C. J. Crosby — ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

Wilson

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085

File No. 14344
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John E. White

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
March (Month) 10 (Day) 1858 (Year)

7. AGE
58 Yrs. 1 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Physician
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Edward White

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Caroline Edmund

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary A. Hale
(Address) Twin Falls Ida

15.
Filed 4-16 1916 John K. Coughlen Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
4 (Month) — 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12 1916, to April 14 1916, that I last saw him alive on April 13 1916, and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. Wilson M. D.

April 15 1916 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Twin Falls — DATE OF BURIAL: 4-17 1916

20. UNDERTAKER: C. J. Crosby — ~~ADDRESS~~: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of (If outside limits of city or village, write the word "Not" before "In")
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..... , ... St.)

File No. 14345
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Fajen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Male~~ Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widowed
6. DATE OF BIRTH. July (Month) 25 (Day) 1841 (Year)
7. AGE: 74 Yrs. 8 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... House Work (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Germany
10. NAME OF FATHER Henry Holtgen
11. BIRTHPLACE OF FATHER (State or Country) Germany
12. MAIDEN NAME OF MOTHER Dorothea Kuenzi
13. BIRTHPLACE OF MOTHER (State or Country) Germany
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P. C. Fisher
(Address) Twin Falls
15. Filed 4-19 1916 H. Engleman Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 17 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1916, to April 15 1916, that I last saw her alive on April 15 1916, and that death occured on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Carcinoma of stomach
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H. Worden M. D.
April 17 1916 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Stover Mo. DATE OF BURIAL: ..... 191.....
20. UNDERTAKER: G. F. Goodman ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 14346
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Twin Falls
City of .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Cora Mason

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. 5th (Month) (Day) 1877 (Year)

7. AGE ..... Yrs. ..... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) N. C.

10. NAME OF FATHER John Hobson

11. BIRTHPLACE OF FATHER (State or Country) North Calina

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) North Calina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. L. Mason
(Address) Twin Falls Ida

15.
Filed 4 - 8 1916
J. Coughlen
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 6th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/24/1916, to 4/6/1916,
that I last saw her alive on 4/6/1916,
and that death occured on the date stated above, at 4:50 P M.

The CAUSE OF DEATH* was as follows:
General sepsis

(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Abortion

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. O. F. Pike M. D.
4/10/1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls — DATE OF BURIAL 4-8 1916

20. UNDERTAKER C. Crosby — ADDRESS T Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14347

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of [illegible]

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. ....., ... St.)

2. FULL NAME Mrs. Eliza Faick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 31st (Day) 1840 (Year)

7. AGE: 75 Yrs. 5 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: X Buick

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. E. Carlson

(Address) .....

15. Filed 4-1 1916

J. H. Vaughn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 1916, to April 20 1916, that I last saw her alive on April 20 1916 and that death occured on the date stated above, at 6.45 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Wilson M. D.

April 22 1916 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Teresco Nebr — DATE OF BURIAL: April 1916

20. UNDERTAKER: J. Crosby — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14348

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 37

Primary Registration District No. 1085

County of Twin Falls Ida

City of Twin Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Goehring

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 1 (Day) 1893 (Year)

7. AGE: 22 Yrs. 6 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): North Dakota

10. NAME OF FATHER: Henry Bertsch

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. J. Goehring

(Address) Kimama Ida.

15. Filed 4-20 1916 J. H. Coughran Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1916, to April 19 1916, that I last saw her alive on April 19 1916, and that death occured on the date stated above, at 6.30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) Pregnancy

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. O. Boyle M. D.

Apr 19 1916 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF [illegible] OR REMOVAL: Ashley North Dakota

DATE OF BURIAL ..... 191..

20. UNDERTAKER: P. J. Grossman

ADDRESS Shelley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BKRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1095
File No. 14349
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter J. Doyle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
June (Month) 4 (Day) 1871 (Year)

7. AGE
44 Yrs. 10 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Mining
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) England.

10. NAME OF FATHER William Doyle

11. BIRTHPLACE OF FATHER
(State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary Dunn

13. BIRTHPLACE OF MOTHER
(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Hillary Doyle
(Address) Twin Falls Ida,

15.
Filed 4-13 1916
J. F. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1916, to April 11 1916, that I last saw h[im] alive on April 11 1916, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Interstitial Nephritis

(Duration) 4 Yrs. mos. ds.
Contributory (Secondary) Interstitial nephritis

(Duration ..... yrs. ..... mos. ..... ds.
(Signed) John F. Coughlin M. D.
4-13 1916 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: April 15 1916

20. UNDERTAKER: Grossman & Evans
ADDRESS: Twin Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-15

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 14350
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls.
City of Hansen (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Ann Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Jan. 21 (Month) (Day) 1864 (Year)
7. AGE: 52 Yrs. 2 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Kansas
10. NAME OF FATHER: David Sample
11. BIRTHPLACE OF FATHER (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Nancy Foolia
13. BIRTHPLACE OF MOTHER (State or Country): Md
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas A Jones
(Address) Hansen Idaho.
15. Filed 3-29 1916 J H Sawyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 28 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 28 1916, to March 28 1916, that I last saw her alive on March 28 1916, and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Internal injuries - probably ruptured viscera with hemorrhage
(Duration) ..... Yrs. ..... mos. 4 hours
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) E Owwods M. D.
4-3 1916 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: 4-1 1916
20. UNDERTAKER: Thompson & Enos ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5-9
Primary Registration District No. 2139
File No. 5-14351
Registered No.

1. PLACE OF DEATH.
County of Blaine
City of Moore
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Kersell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Aug (Month) 31 (Day) 1827 (Year)

7. AGE: 88 Yrs. 9 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Devonshire, England

10. NAME OF FATHER: George Kersell

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: Sarah Farley

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Lon King
(Address) Moore, Idaho

15. Filed 5/13 1916
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24958

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 7.30 a. M.

The CAUSE OF DEATH* was as follows:
Senile Debility

..... (Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Apoplexy
4 (Duration) ... yrs. ... mos. ... ds.
(Signed) Lon King M. D.
5/13/16 (Address) Moore, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 3 yrs. 7 mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Provo, Utah

19. PLACE OF BURIAL OR REMOVAL: Moore, Idaho
DATE OF BURIAL: 5/15 1916

20. UNDERTAKER: Lon King
ADDRESS: Moore, Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2139
(No. ....., ... St.)

File No. 53
Registered No. 14352

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Blaine
City of Ames
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Merlin Curtis

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
May (Month) 5 (Day) 1911 (Year)

7. AGE
5 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Hyrum, Utah

10. NAME OF FATHER
Henry Warren Curtis

11. BIRTHPLACE OF FATHER
(State or Country) Hyrum, Utah

12. MAIDEN NAME OF MOTHER
Maney Parker

13. BIRTHPLACE OF MOTHER
(State or Country) Wellsville, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry Curtis
(Address) Ames, Idaho

15.
Filed 4/20 1916 Ewt
Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/19 1916, to 4/20 1916, that I last saw h[illegible] alive on 4/20-7 a.m. 1916, and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Acute Meningitis
Inflammatory Malaria
Fever
24 hours (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) Ewt M. D.
4/20 1916 (Address) Ames, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ames, Idaho
DATE OF BURIAL: 4/22 1916

20. UNDERTAKER: Henry Curtis
ADDRESS: Ames, Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 14353
Registered No. 6

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Clarsia Wood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Feb 9 1916 (Month) (Day) (Year)

7. AGE: X Yrs. X Mos. X ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malad Idaho

10. NAME OF FATHER: Heber Wood

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Delila Rogers

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Heber Wood
(Address) Arbon Idaho

15. Filed 2-10 1916 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 10 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-9 1916, to 2-10 1916, that I last saw her alive on 2-10- 1916, and that death occured on the date stated above, at 2 30 A.M.

The CAUSE OF DEATH* was as follows:
Congenital weakness

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.
2-10 1916 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad City Cem. DATE OF BURIAL: Feb 10 1916

20. UNDERTAKER: Bird Thompson ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVIHS - YORK CO., PTRS. & BOOS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 14354
Registered No. 7

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No.) (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julian Claudius Wood

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write one word.): Married

6. DATE OF BIRTH. Feb (Month) 9 (Day) 1916 (Year)

7. AGE: X Yrs. X Mos. X ds.
IF LESS than 1 day how many ½ hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Malad Idaho

10. NAME OF FATHER Heber Wood

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Delila Rogers

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Heber Wood
(Address) Arbon Idaho

15. Filed 2-10 1916 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9 1916, to 2-9 1916, that I last saw him alive on 2-9 1916, and that death occured on the date stated above, at 8 45 P.M.

The CAUSE OF DEATH* was as follows:
Congenital weakness

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) D C Ray M. D.
2-10 1916 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad City Cem. DATE OF BURIAL: Feb 10 1916

20. UNDERTAKER: Burt Thompson ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & ENGS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

Primary Registration District No. 2071

File No. 14356

Registered No. 6

County of Oneida

City of Holbrook (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amanda Garn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Wid

6. DATE OF BIRTH: February (Month) 1st (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ✓
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Holbrook Ida

10. NAME OF FATHER Horace A. Garn

11. BIRTHPLACE OF FATHER (State or Country) Fielding Utah

12. MAIDEN NAME OF MOTHER Chloe L. Sweeten

13. BIRTHPLACE OF MOTHER (State or Country) Mendon Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chloe L Garn
(Address) Holbrook Idaho

15. Filed 2-16 1916 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 3d (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h[illegible] alive on 2-3 1916,
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows: Myocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

19..... (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Holbrook Idaho | DATE OF BURIAL: Feb 5th 1916

20. UNDERTAKER: Home | ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2086
(No. ..... St.)

File No. 14358
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Coleman Hinkley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Mar. (Month) 24 (Day) 1916 (Year)

7. AGE: X yrs. mos. 47 ds.
IF LESS than 1 day how many ..... *hrs.* or ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Filer Ida

10. NAME OF FATHER: Frank Hinkley

11. BIRTHPLACE OF FATHER (State or Country): Newyork

12. MAIDEN NAME OF MOTHER: Elizabeth Peck

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. G. A. Newberry
(Address) Filer Ida

15. Filed May 11 1916 G. A Newberry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9 1916, to May 10 1916, that I last saw h/m alive on May 10 1916, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. A. Newberry M. D.
19 .... (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Cemetery — DATE OF BURIAL: May 11 1916

20. UNDERTAKER: Frank Hinkley — ADDRESS: Filer

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14359

Registered No. 10

1. PLACE OF DEATH.

County of Oneida

City of Malad

Registration District No. 26

Primary Registration District No. 2069

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Mary Richards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (X) Nov (Month) 11 (Day) 1913 (Year)

7. AGE: ..... Yrs. 3 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thos. C. Richards

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Hazel Lulla Bingham

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas C. Richards Jr.

(Address) Malad

15. Filed 2-21 1916 D C Ray Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-17 1916, to 2-19 1916, that I last saw her alive on 2-19 1916, and that death occured on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.

2/21 1916 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad City Cem — DATE OF BURIAL: 2-21 1916

20. UNDERTAKER: V. Bne Thompson — ADDRESS: Malad

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 14360
Registered No. 8

1. PLACE OF DEATH.
County of Oneida
City of Malad

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Alfred

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Feb (Month) 4 (Day) 1871 (Year)

7. AGE: 44 Yrs. 11 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: William Jones

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Margaret Roderick

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Kirm Alfred
(Address) Malad Idaho

15. Filed 2-4 1916 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1915, to Feb 2 1916, that I last saw her alive on 2-2 1916, and that death occured on the date stated above, at 11:15 P M.

The CAUSE OF DEATH* was as follows:
Chronic endometritis
operation removal of uterus - Septicemia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. 21 ds.
(Signed) D C Ray M. D.
2-4 1916 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad City Cem. DATE OF BURIAL: Feb 7 1916

20. UNDERTAKER: Bone Thompson ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 96

Primary Registration District No. 2069

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14361

Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Cassia

City of Malad

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Ann Richards

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec. (Month) 15 (Day) 1862 (Year)

7. AGE: 54 Yrs. 1 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Morris Jones

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Sarrah J. James

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John M. Richards

(Address) Malad, Idaho

15. Filed 2-14 1916 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 12th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 20 1916, to Feb 12 1916, that I last saw her alive on 2-12 1916 and that death occured on the date stated above, at 10:45 P.M.

The CAUSE OF DEATH* was as follows:

Emphysema

(Duration) 10 Yrs. mos. ds.

Contributory (Secondary) Dilatation of heart

(Duration) Yrs. 3 mos. ds.

(Signed) D C Ray M. D.

2-14 1916 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad City Cem. DATE OF BURIAL: 2-12 1916

20. UNDERTAKER: Bert Thompson ADDRESS: Malad

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 14362
Registered No. 11

1. PLACE OF DEATH.
County of Cassia
City of Malad
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Stubbs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH. July (Month) 31 (Day) 1841 (Year)

7. AGE 74 Yrs. 7 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Isaac Stubbs

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Ann Exton

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ellen Stubbs
(Address) Malad Idaho

15. Filed 3-2 1916 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1916, to Feb 28 1916, that I last saw h[illegible] alive on Feb 28 1916 and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
La Grippe
(Duration) ..... Yrs. ..... mos. 12 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.
3-2 1916 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad City Cem	May 2 1916
20. UNDERTAKER V B Thompson	ADDRESS Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BKBS. 24053

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 14363
Registered No. 17

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary E. Erickson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
April 30 1876
(Month) (Day) (Year)

7. AGE
39 Yrs. 10 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Michigan

10. NAME OF FATHER
Peter Ortwine

11. BIRTHPLACE OF FATHER
(State or Country) Germany

12. MAIDEN NAME OF MOTHER
Unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. A. Erickson
(Address) Malad Idaho.

15.
Filed Mch 17 1916
O. C. Ray
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24852

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 14 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1915, to March 14 1916, that I last saw her alive on March 10 1916, and that death occured on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

3/16 1916 (Signed) J. F. Alton M. D.
(Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad City, Idaho. DATE OF BURIAL: 3-17 1916

20. UNDERTAKER: John M. Richards ADDRESS: Malad, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14364

Registered No. 3

1. PLACE OF DEATH.

County of Oneida

City of Malad

Registration District No 76

Primary Registration District No 7069

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Evans

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Sept (Month) 28 (Day) 1858 (Year)

7. AGE 57 Yrs. 3 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) South Wales

10. NAME OF FATHER Joshua Evans

11. BIRTHPLACE OF FATHER (State or Country) So. Wales

12. MAIDEN NAME OF MOTHER Hannah Richards

13. BIRTHPLACE OF MOTHER (State or Country) So. Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joshua F. Evans

(Address) Malad

15. Filed 1-10 1916 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1913, to Jany 1916, that I last saw h alive on Jany 4 1916 and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows: Chronic Valvular heart

..... (Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Dropsy

..... (Duration) 2 Yrs. 4 mos. ..... ds.

(Signed) D C Ray M. D.

1-10 1916 (Address) Malad City Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad City Cemetery — DATE OF BURIAL: Jan 12 1916

20. UNDERTAKER: Bert Thompson — ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14365

Registered No. ____

1. PLACE OF DEATH.

County of Oneida

City of Malad

Registration District No. 26

Primary Registration District No. 2069

(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reva Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Dec (Month) 18 (Day) 1915 (Year)

7. AGE: ____ Yrs. ____ Mos. 15 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Fredrick R. Jones

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Evelyn Hanson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick R Jones

(Address) Malad Idaho

15. Filed 1-17 1916 D C Berry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1915, to Jan 1 1916, that I last saw he alive on Jan 1 1916, and that death occured on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Marasmus.

(Duration) Yrs. ____ mos. 15 ds.

Contributory (Secondary) Cerebritis.

(Duration ____ yrs. ____ mos. 14 ds.

(Signed) J. M. Kinsman M. D.

1/18 1916 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL, OR REMOVAL: Malad City Cem. DATE OF BURIAL: Jan 3 1916

20. UNDERTAKER: Thompson ADDRESS: Malad

BYRON - WEBER CO., PTRS. & STNRS. 24058

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 36

County of Blaine

Primary Registration District No. 2621

File No. 14366

City of Glenns Ferry (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howard Plummer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. October (Month) 17 (Day) 1881 (Year)

7. AGE: 34 Yrs. 4 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farming
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Grayson co Va

10. NAME OF FATHER Felix Plummer

11. BIRTHPLACE OF FATHER (State or Country) Ash, Co., N. C.

12. MAIDEN NAME OF MOTHER Sesanah Wiles.

13. BIRTHPLACE OF MOTHER (State or Country) Grayson, co. Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lucile Plummer
(Address) Hill City Idaho

15. Filed May 29 1916 J. W. Davis M D Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 18 1916, to March 11 1916, that I last saw h.... alive on March 11 1916, and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) Yrs. 5 mos. — ds.

Contributory (Secondary)

(Duration — yrs. — mos. — ds.

(Signed) W. F. Morrison M. D.
March 11 1916 (Address) Glenns Ferry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Glenns Ferry — DATE OF BURIAL: March 12, 1916

20. UNDERTAKER: J. M. Corwin — ADDRESS: Mt Home Idaho

MARGIN RESERVED FOR BINDING. WRITE PLAINLY, WITH UNFADING INK. N. B.—Every item of information should be carefully supplied. Data should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Statement of OCCUPATION is very important. See instructions on back of certificate.

AVIS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14367

Registered No.

1. PLACE OF DEATH.

Registration District No. 35

Primary Registration District No. 2021

County of Elmore

City of Glenns Ferry (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Muriel E. Robin-Hoernaker

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: December 27 (Month) (Day) 1906 (Year)

7. AGE: Nine yrs. 4 mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: school pupil
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canton, Ohio

10. NAME OF FATHER: Geo. Robin

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: Pearl Robin

13. BIRTHPLACE OF MOTHER (State or Country): Canton, Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pearl Hoernaker
(Address) Glenns Ferry Idaho

15. Filed May 4th 1916 J. W. Doris Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 3rd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

caused by gunshot wound

X (Duration) 40 minutes yrs. mos. ds.

Contributory (Secondary) (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Easton M. D.

May 3 1916 (Address) Coroner Glenns Ferry Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glenns Ferry Ida. DATE OF BURIAL: May 4th 1916

20. UNDERTAKER: J. McCowen By Easton ADDRESS: Mtn Home Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 35
Primary Registration District No. 2021
File No. 14368
Registered No. ____

1. PLACE OF DEATH.
County of Elmore
City of Glenns Ferry (No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME C. J. Shoemaker

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
(Month) " (Day) " 1881 (Year)

7. AGE: 35 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Locomotive Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: C Shoemaker

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A Coexpatriot
(Address) Montpelier Ida

15. Filed May 11th 1916 J. W. Doris Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 3d (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3d 1916, to May 3d 1916, that I last saw him alive on May 1st 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Gunshot wound of chest

(Duration) Short Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____
(Duration ____ yrs. ____ mos. ____ ds.

(Signed) J. W. Doris M. D.
May 3. 1916 (Address) Glenns Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? ....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Lenny Ill — DATE OF BURIAL: May 5 1916

20. UNDERTAKER: J. M. Cowen — ADDRESS: Mountain Home Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4

County of Canyon

Primary Registration District No. 1008

City of Payette (No. ....., ... St.)

File No. 14369

Registered No. 78

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Kirkendall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
~~3.~~ Female	White	Single

6. DATE OF BIRTH: May (Month) 28 (Day) 1916 (Year)

7. AGE: — yrs. — mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Son Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A. B. Kirkendall

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Daisy Brown

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A B Kirkendall

(Address) Payette

15. Filed May 11 1916 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28 1916, to May 8 1916, that I last saw her alive on May 8 1916, and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Avery M. D.

5/10/ 1916 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida | DATE OF BURIAL: May 10 1916

20. UNDERTAKER: D Hudair | ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Custer
City of Mackay
(No. .... St.)
Registration District No. 76
Primary Registration District No. 2153
File No. 14370
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tony Barrick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unknown (Month) 1 (Day) (Year)

7. AGE: About 25 yrs. Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... General laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Probably in Austria

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dr N.H. Fanell
(Address) Mackay Ida

15.
Filed May 18 1916 R. Marie Sears Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1916, to May 17 1916, that I last saw him alive on May 17 1916, and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Double lobar pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) N.H. Fanell M. D.
5/18 1916 (Address) Mackay Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mackay, Ida — DATE OF BURIAL: May 18 1916

20. UNDERTAKER: J. L. Baxter — ADDRESS: Mackay, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14371
Registered No.

1. PLACE OF DEATH.
County of Custer
City of Challis
Registration District No.
Primary Registration District No.
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jake Allen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed
6. DATE OF BIRTH: Dont Know (Month) (Day) 1840 (Year)
7. AGE: 76 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Dont Know
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Mo.
10. NAME OF FATHER: Dont Know
11. BIRTHPLACE OF FATHER (State or Country): Dont Know
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (State or Country): Dont Know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Tiffe
(Address) Challis
15.
Filed 191 6 H. C. Lowell
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 5 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr 11 1916, to May 5 1916
that I last saw h[illegible]alive on May 3 1916
and that death occurred on the date stated above, at 4 a. M.
The CAUSE OF DEATH* was as follows:
Nephritis
(Duration) yrs. 6 mos. ds.
Contributory (Secondary) Paralysis, cysteitis
(Duration) yrs. mos. ds.
(Signed) J. W. Kelley M. D.
May 5 19 16. (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 4 ds. In the State Dont Know yrs. mos. ds.
Where was disease contracted, if not at place of death? MacKay, Ida.
Former or usual residence MacKay, Ida.

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL 191

20. UNDERTAKER — ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14372
Registered No.

1. PLACE OF DEATH.
County of Custer
City of Challis
Registration District No.
Primary Registration District No.
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Michael Carter

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 1826 (Month) (Day) (Year)

7. AGE: 90 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dont Know

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Tippe
(Address) Challis

15.
Filed May 5 1916
H C. LaMell
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6 1916, to Apr 30 1916, that I last saw h alive on Apr 29 1916 and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Old age.
General weakness

(Duration) yrs. mos. 24 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J W Kelley M. D.
May 1916 (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. mos. ds.
In the State Dont Know yrs. mos. ds.
Where was disease contracted, if not at place of death? ?
Former or usual residence Bonanza Ida

19. PLACE OF BURIAL OR REMOVAL
DATE OF BURIAL 191

20. UNDERTAKER
ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49 2+28

Primary Registration District No. 2128

File No. 14373

Registered No. .....

1. PLACE OF DEATH.

County of Lewis

City of Kamiah

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Archie McFarland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Indian	Single

6. DATE OF BIRTH: July (Month) 10 (Day) 1901 (Year)

7. AGE: 14 yrs. 10 mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Going to School
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Francis McFarland

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Rebecca Blackeagle

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Blackeagle
(Address) Kamiah

15. Filed 5/10 1916 W. F. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
..... (Month) ..... (Day) ..... 191.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 15th. 1916, to 5/13 1916, that I last saw him alive on 5/9/1916, and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Phthisis Pulmonalis

(Duration) 2 Yr. yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. McMahan M. D.

19.... (Address) Kamiah, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Cemt # 2 — DATE OF BURIAL: 5/15 — 1916

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kamiah, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14374
Registered No.

1. PLACE OF DEATH.
County of Lewis
City of Kamiah
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 49
Primary Registration District No. 2128
(No. ....., ... St.)

2. FULL NAME Julia Moffett.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Don't know ..... (Month) ..... 1 (Day) ..... (Year)

7. AGE: about 30 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house keeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho County.

10. NAME OF FATHER: Don't know

11. BIRTHPLACE OF FATHER (State or Country): Nez Perce. Co.

12. MAIDEN NAME OF MOTHER: Don't know.

13. BIRTHPLACE OF MOTHER (State or Country): Don't know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry A. Moffett.
(Address) Kamiah

15. Filed 4/17 1916 W. T. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 4 (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/16 1916, to same 1916, that I last saw her alive on same 1916, and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:
Tubercular Peritonitis

(Duration) ? yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. T. McMahan M. D.
19 ..... (Address) Kamiah Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: ~~I.O.O.~~ Ind. Cem. * r — DATE OF BURIAL: 4/18 1916

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kamiah Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Deary
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2147
Primary Registration District No. 67
(No. ....., ... St.)

File No. 14375
Registered No. 29
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Botilda Peterson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Apr. (Month) 26 (Day) 1835 (Year)

7. AGE: 80 yrs. 11 mos. 24 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: H. W.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Lars Johnson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Amelia Olson.

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C Hoffman
(Address) Deary Idaho

15. Filed April 10 1916 P. E. Faust
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
old age reported

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Zion Cemetery
DATE OF BURIAL: 4-22 1916

20. UNDERTAKER: ~
ADDRESS: ~

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
(No. ..... , ... St.)

File No. 14376
Registered No. 117

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Cassia
City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada Leona Hogg.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Feb. (Month) 1 (Day) 1902 (Year)

7. AGE
14 Yrs. 2 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... In School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER R. Hogg.

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Gina Jane Butters.

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. Hogg
(Address) Burley Idaho

15.
Filed Apr 18th 1916. Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr. (Month) 17th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 2 1916, to Apr. 17 1916, that I last saw h[illegible] alive on Apr. 16 1916, and that death occured on the date stated above, at 2a M.

The CAUSE OF DEATH* was as follows:
Typhoid

(Duration) Yrs. mos. 20 ds.

Contributory (Secondary) .....
(Duration yrs. mos. ds.

(Signed) J. C. Patterson M. D.
4-17 1916 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: April 19 1916

20. UNDERTAKER: L. B. Gallogly ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24953

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1016
File No. 14377
Registered No. 5

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): New born Babe

6. DATE OF BIRTH.
Apr (Month) 18 (Day) 1916 (Year)

7. AGE
..... Yrs. ..... Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... X
(b) General nature of industry, business, or establishment in which employed (or employer)... X

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Clarence Eugene Wilson

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Emma McCormick

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. E. Wilson
(Address) Shoshone, Ida.

15.
Filed Jan 25 1916
J. L. Fuller
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1916, to Apr. 25 1916, that I last saw him alive on Apr. 25 1916, and that death occured on the date stated above, at 9A. M.

The CAUSE OF DEATH* was as follows:
Asthenia
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. L. Fuller M. D.
19..... (Address) Shoshone, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Q. Burman — DATE OF BURIAL: 4/26 1916

20. UNDERTAKER — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 16
Primary Registration District No. 2016
(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14378
Registered No. 3

1. PLACE OF DEATH.
County of Lincoln
City of Haddock
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Umbelina Gomes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Portugese
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH. Will send exact age later.
Approximately (Month) 1 (Day) 88 (Year)

7. AGE: 85 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... X
(b) General nature of industry, business, or establishment in which employed (or employer)... X

9. BIRTHPLACE (State or Country) Azore Islands.

10. NAME OF FATHER Francisco Antonio de Souza

11. BIRTHPLACE OF FATHER (State or Country) Azore Islands

12. MAIDEN NAME OF MOTHER Maria de Chaves

13. BIRTHPLACE OF MOTHER (State or Country) Azore Islands

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anthony M. Gomes
(Address) Haddock

15. Filed April 17 1916 J. L. Turner Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15 1916, to April 15 1916, that I last saw h[illegible] alive on April 15 1916, and that death occured on the date stated above, at 11 a. M.

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency
& Cardiac Dropsy

(Duration) Several Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Keller M. D.
19..... (Address) Shoshone, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: Apr 18 1916

20. UNDERTAKER: O. J. Brennan — ADDRESS: Shoshone

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 16

Primary Registration District No. 1016

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14379

Registered No. 6

1. PLACE OF DEATH.

County of Lincoln

City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Rebecca Burgan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Caucasian

5. ~~SINGLE, MARRIED, WIDOWED OR DIVORCED.~~ Widowed (Write the word.)

6. DATE OF BIRTH. Dec 11 (Month) 1843 (Day) (Year)

7. AGE: 72 Yrs. 4 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... X

(b) General nature of industry, business, or establishment in which employed (or employer)... Property Holder

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. H. Badgley

(Address) Shoshone Ida.

15. Filed Apr 30 1916

J. H. Turner
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1915, to Apr. 28 1916, that I last saw her alive on Apr. 28 1916 and that death occured on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Myocardial Degeneration

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senile Dementia Nephritis

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Zeller M. D.

19..... (Address) Shoshone Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone Ida. DATE OF BURIAL: 4/30 1916

20. UNDERTAKER: Brennan ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 46
Primary Registration District No. 2173
(No. ....., ... St.)

File No. 14380
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bonnuah
City of Plummer.

2. FULL NAME Kenneth Allen Olum

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 9th (Day) 1916 (Year)

7. AGE: ..... Yrs. ..... Mos. 3 ds.
IF LESS than 1 day how many 7 hrs. or 15 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Plummer, Idaho.

10. NAME OF FATHER: Benjamine A. Olum.

11. BIRTHPLACE OF FATHER (State or Country): Allen Co, Ohio.

12. MAIDEN NAME OF MOTHER: Nora. May. Mitchell.

13. BIRTHPLACE OF MOTHER (State or Country): Detroit, Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ben. A Olum
(Address) Plummer, Idaho.

15. Filed May 17 1916 H. L. Jaeger Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9th 1916, to May 12th 1916, that I last saw him alive on May 10th 1916, and that death occured on the date stated above, at 12-30 P.M.

The CAUSE OF DEATH* was as follows: Acute Indigestion

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary): None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. C. Harrington M.D.
May 17 1916 (Address) Plummer, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Plummer, Idaho. DATE OF BURIAL: May 13 1916

20. UNDERTAKER: H. L. Jaeger. ADDRESS: Plummer, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & MDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Boise

Primary Registration District No. 2019

File No. 14382

City of Horseshoe Bend (No. ....., ... St.)

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ole Jackson County Hospital

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH ..... (Month) ..... 1 (Day) ..... (Year)

7. AGE About 85 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Day Labor.
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed May 10 1916 May Fitz Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~1916~~ Never attended, to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... P. M.

The CAUSE OF DEATH* was as follows:

Unknown.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. J. Fitz M. D.

May 10 1916 (Address) Placerville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? County Hospital

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Horseshoe Bend	May 6 1916
20. UNDERTAKER	**ADDRESS**
Dad more.	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Boise

Primary Registration District No. 2019

File No. 14383

City of Idaho City

(No. ....., ... St.)

Registered No. 86

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fo Gone

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: Chinese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1830 (Year)

7. AGE: 86 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day Laborer.
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15.

Filed May 10 1916 May Fey DeSilva
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from never attended 191, to 191,
that I last saw h..... alive on 191,
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Unknown.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. G. Fitz M. D.

19 (Address) Placerville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho City. DATE OF BURIAL: Apr 15 1916

20. UNDERTAKER: Had none. ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

[redacted]CATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration [redacted] No. 27

Primary Registration District No. 2119

File No. 14384

Registered No. 12

1. PLACE OF DEATH.

County of [redacted]

City of Whitney (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ursina Fasler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. ~~SINGLE~~, ~~MARRIED~~, WIDOWED OR ~~DIVORCED~~. [redacted] (Write the word.)

6. DATE OF BIRTH. 8 (Month) 15 (Day) 1824 (Year)

7. AGE 87 Yrs. 8 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Switzerland

10. NAME OF FATHER Joseph Fasler

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Barbara Schaffhauser

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Fasler

(Address) Whitney Idaho

15.

Filed 5/10 1916 D. A. Cutler Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 (Month) 28th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 27 1916, to Apr 28 1916, that I last saw her alive on Apr 28 1916, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) Yrs. 2 mos. — ds.

Contributory (Secondary) Chronic Softening Brain

(Duration 2 yrs. — mos. — ds.

(Signed) G. W. Caldwell M. D.

Apr 29 1916 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Logan, Ut. DATE OF BURIAL: 191

20. UNDERTAKER: J. A. Lundquist per S. K. ADDRESS: Logan

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14385

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Franklin

City of Preston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rasmussen Christian Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. April (Month) 6 (Day) 1916 (Year)

7. AGE: 45 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Grain dealer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: R. C. Peterson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Anna Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Ilford Peterson

(Address) .....

15.

Filed ..... 191.....

Dan Rutter
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1916, to April 6 1916, that I last saw him alive on April 5 1916, and that death occured on the date stated above, at 1:45 P M.

The CAUSE OF DEATH* was as follows:

Bright's disease
(Nephritis)

(Duration) One Yrs. ✓ mos. ✓ ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G. W. Oates M. D.

Apr 7 1916 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Trink Creek — DATE OF BURIAL ..... 191.....

20. UNDERTAKER: H. A. Gilmore per A. A. Mason — ADDRESS .....

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14386

Registered No. 13

1. PLACE OF DEATH.

County of Franklin Co

City of Franklin

(No. ....., ... St.)

Registration District No 27

Primary Registration District No 2119

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alton Jones Fuhriman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Oct. (Month) 8 (Day) 1912 (Year)

7. AGE: 3 Yrs. 6 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Child

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Franklin Idaho

10. NAME OF FATHER Andrew E Fuhriman

11. BIRTHPLACE OF FATHER (State or Country) Providence Utah

12. MAIDEN NAME OF MOTHER Effa Jones

13. BIRTHPLACE OF MOTHER (State or Country) Farmington Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew E. Fuhriman

(Address) Franklin

15. Filed 5/10 1916

D. A. Preston Idaho
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17 1916, to April 18 1916, that I last saw him alive on April 15 1916, and that death occured on the date stated above, at 1/2 M.

The CAUSE OF DEATH* was as follows:

Injury - Crushing of Chest.

(Duration) 1 Yrs. 1 mos. - 1 - ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G W Stokes M. D.

Apr 19 1916. (Address) Preston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Franklin Idaho — DATE OF BURIAL: 4/20 1916

20. UNDERTAKER: W. A. Saidmon — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 218
City of Orofino (No. , St.)
File No. 14387
Registered No. 73
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Harvey M. Bryant
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: January (Month) 4 (Day) 1916 (Year)
7. AGE: yrs. 2 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Harvey Bryant
11. BIRTHPLACE OF FATHER (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Esther Brown
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J M Finley
(Address) Pierce, Ida
15. Filed April 7 1916 J M Finley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 7 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 10 1916, to April 7 1916, that I last saw him alive on April 7 1916, and that death occurred on the date stated above, at 12 00 M.
The CAUSE OF DEATH* was as follows:

Cyanosis

(Duration) yrs. mos. 20 ds.
Contributory (Secondary) Enteritis Colitis
(Duration) yrs. mos. 18 ds.
(Signed) J. M. Finley M. D.
4/7 1916 (Address) Orofino, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gilbert, Ida — DATE OF BURIAL: 4/8 1916
20. UNDERTAKER: W. C. Stoddard — ADDRESS: Gifford, Ida

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 14390
Registered No. 32

1. PLACE OF DEATH.
County of Clearwater
City of Orofino Ida
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Holden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. — (Month) — (Day) 1846 (Year)

7. AGE: 70 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A B Clanton
(Address) Orofino, Ida

15. Filed May 1 1916
J M Haines
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1916, to April 21 1916, that I last saw h[illegible] alive on April 21 1916, and that death occured on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH* was as follows:
Cystitis

(Duration) Yrs. 6 mos. ..... ds.
Contributory (Secondary) Insanity
(Duration 1 yrs. 6 mos. ..... ds.

(Signed) John W Givens M. D.
Apr. 2 1916 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Orofino Ida ..... yrs 12 mos. 21 days. In the N. I. Sanitarium State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida
DATE OF BURIAL: May 27 1916

20. UNDERTAKER: W E Haddock
ADDRESS: Gifford Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Genesee
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. , St.)

File No. 14391
Registered No. 24
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rebecca DeFriese

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH
(Month) (Day) 1838 (Year)

7. AGE
84 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: -

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Grigsby

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. J. DeFriese
(Address) Genesee Ida

15. Filed 4/13 1916 J. M. Hanley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
(Month) Feby (Day) 17 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 , to 191 , that I last saw h alive on Feby 1st 1916, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Senile Gangrene

(Duration) yrs. 3 mos. ds.
Contributory (Secondary) Old Age & Gen'l debility
(Duration) yrs. 1 mos. ds.

(Signed) J. M. Hanley M. D.
4/13 1916 (Address) Colfax Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sunnyside Cemetery | DATE OF BURIAL: 4/13 1916

20. UNDERTAKER: W. E. Hoskins | ADDRESS: Tekoa, Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

County of

Primary Registration District No. 2184

File No. 14392

City of (No. , St.)

Registered No. 124

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minerva Johanna Brackley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: March (Month) 1 (Day) 1914 (Year)

7. AGE: 2 yrs. 1 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho Co. Idaho

10. NAME OF FATHER Emil Brackley

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Julia Ducepo

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emil Brackley
(Address) Kooskia - Idaho

15. Filed April 5 1916 J M. Culbertson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18 1916, to April 1 1916, that I last saw her alive on March 31 1916, and that death occurred on the date stated above, at 10 00 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. 2 ds.

(Signed) J M. Culbertson M. D.

April 2 1916 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lahoe Country	April 2 1916

20. UNDERTAKER	ADDRESS
Rev Lyeare (Pastor)	Lahoe Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 14393
Registered No. [illegible]

1. PLACE OF DEATH.
County of Idaho
City of Clearwater (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Zelma Margaret Lyda
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March 14 1916 (Month) (Day) (Year)

7. AGE: ____ yrs. 1 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or, employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Perry Lyda

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Eva Oliver

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Perry Lyda
(Address) Clearwater

15.
Filed April 20 1916 J. M. Vuberhaus
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 16th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14 1916 to April 16 1916, that I last saw h W alive on March 16th 1916 and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Inability to assimilate food with convulsion. —

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Seven months child
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W Wentworth M. D.
April 1916 (Address) Stites Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clearwater
DATE OF BURIAL: April 17 191

20. UNDERTAKER: Family
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14394

Registered No. 36

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho

City of States (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. .....

2. FULL NAME Thelma Hutchens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (write the word): Single

6. DATE OF BIRTH: October 7 1907 (Month) (Day) (Year)

7. AGE: 8 yrs. 6 mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Hutchens

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Myrtle Chase

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Irvin R Wisner
(Address) Hapeton

15. Filed April 20 1916 J.M. Verbeck Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 14 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1915 to April 14 1916 that I last saw h. W alive on July 10 1915 and that death occurred on the date stated above, at 2:5a M.

The CAUSE OF DEATH* was as follows:
Failure of foramen ovale to close

(Duration) 8 yrs. 6 mos. 7 ds.

Contributory (Secondary) .....
(Duration) 8 yrs. 6 mos. 17 ds.

(Signed) W. W Wentworth M. D.
Apr 14 1916 (Address) States

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hapeton — DATE OF BURIAL: Apr 15 1916

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

County of Idaho

Primary Registration District No. 2184

File No. 14395

City of Kooskia (No. ....., ... St.)

Registered No. 225

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Fitting

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

Feb ..... 18 .....
(Month) (Day) (Year)

7. AGE

73 yrs. 2 mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Farmer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New York State

10. NAME OF FATHER John Fitting

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Lena Miller

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ed J. Fitting

(Address) Kooskia Idaho

15.

Filed April 17 1916 J. M. Verbeckmoes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 12 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8 191.., to April 12 1916 that I last saw h.. alive on April 8 191.., and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Verbeckmoes M. D.

April 17 1916 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Caldo Cemetery Hears Ridge	April 17 1916

20. UNDERTAKER	ADDRESS
of Family	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

Primary Registration District No. 2184

File No. 14396

County of Idaho

City of Kooskia (No. ....., ... St.)

Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Wesley Henry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 31 (Day) 1840 (Year)

7. AGE: 75 yrs. 6 mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hotel Keeper
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: James Franklin Henry

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Elsie Benton

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Anna Henry

(Address) Kooskia - Idaho

15.

Filed April 20 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1916, to April 17 1916, that I last saw him alive on April 17 1916, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Shoberkamp M. D.

April 18 1916 (Address) Kooskie - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Kooskie Cemetery — DATE OF BURIAL: April 19 1916

20. UNDERTAKER: Kooskie Mercantile — ADDRESS: Kooskie

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 59

Primary Registration District No. 2139

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4397

Registered No. .....

1. PLACE OF DEATH.

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edna Reta Morris

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 5 (Day) 1916 (Year)

7. AGE: ....Yrs. 1 Mos. 25 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Moscow, Idaho

10. NAME OF FATHER: C. Bert Morris

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Edna Haggie

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harold Hamburg

(Address) Moscow, Idaho

15. Filed 3/31 1916 Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....1916...., to ....1916....,

that I last saw h.....alive on .....1916....,

and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Whooping Cough.

No medical attendance

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

3/31 1916 (Signed) Lucy Fort M. D.

(Address) Avon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow, Idaho

DATE OF BURIAL: 3/31/1916

20. UNDERTAKER: Harold Hamburg

ADDRESS: Moscow, Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2139
File No. 14399
Registered No. [illegible]

1. PLACE OF DEATH.
County of Blaine
City of Hailey
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Miel Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. March 1 (Month) 1 (Day) 1916 (Year)
7. AGE: ..... Yrs. 1 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Hailey, Idaho
10. NAME OF FATHER: William Allen Clark
11. BIRTHPLACE OF FATHER (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Caroline Lusty
13. BIRTHPLACE OF MOTHER (State or Country): South Dakota
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. W. A. Clark
(Address) Hailey, Idaho
15. Filed 4/10 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 5 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Shooting Dough
Immediate attendance
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
4/5 1916 (Signed) [illegible] M. D.
(Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bellevue, Idaho
DATE OF BURIAL: 4/6 1916
20. UNDERTAKER: W. A. Clark
ADDRESS: Hailey, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SWAB - YORK CO., PTRS. & BOOKB. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2139
File No. 46
Registered No. 14400

1. PLACE OF DEATH.
County of Blaine
City of Moore (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 3 (Month) 10 (Day) 1916 (Year)

7. AGE: [redacted] Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Moore, Idaho

10. NAME OF FATHER: William Harris

11. BIRTHPLACE OF FATHER (State or Country): Bear Lake, Idaho

12. MAIDEN NAME OF MOTHER: Sylvia Heaps

13. BIRTHPLACE OF MOTHER (State or Country): Layfield Co., Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Tom Harris
(Address) Moore, Idaho

15. Filed 3/10 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/10 1916, to 3/10 1916, that I last saw her alive on 3/10 1916, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
(Duration) Pneumonia
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

3/10 1916 (Signed) [illegible] M. D.
(Address) Moore, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moore, Idaho — DATE OF BURIAL: 3/12 1916

20. UNDERTAKER: Tom Harris — ADDRESS: Moore, Idaho

SYMS - YORK CO., PTRS. & STRS. 24053

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF [redacted] — CERTIFICATE OF DEATH

County of Bear Lake — Registration District No. 59

City of Paris — (No. ..... St.) — Primary Registration District No. [redacted]

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Mary L. Hart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 21

Registered No. 14401

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec. (Month) 22 (Day) 1875 (Year)

7. AGE: 41 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Farmington, Utah

10. NAME OF FATHER: James Steed

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ruth Richardson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hart

(Address) Paris, Idaho

15. Filed 4/11 1916 — Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/5 1916, to 4/10 1916, that I last saw h[illegible] alive on 4/10 1916, and that death occured on the date stated above, at 5.15 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

Operation Resorted

(Duration) Yrs. ..... mos. 15 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

4/10 1916 (Signed) [signature] M. D.

(Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... dayz

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris, Idaho — DATE OF BURIAL: 4/12 1916

20. UNDERTAKER: Howard Buckham — ADDRESS: Bloomington

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Blaine

City of Ames

Registration District No. 59

Primary Registration District No. 2139

(No. ..... St.)

File No. 11102

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Miss Elvira Frantzes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. July (Month) 1 (Day) 1888 (Year)

7. AGE: 27 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kent Co. Mich.

10. NAME OF FATHER: James Sidney Toland

11. BIRTHPLACE OF FATHER (State or Country): Kent Co. Michigan

12. MAIDEN NAME OF MOTHER: Ina Weaver

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jess Toland

(Address) Ames, Idaho

15. Filed 4/10 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/7 1916, to 4/10 1916, that I last saw her alive on 4/10 1916, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis

(Duration) 12 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. W. Fox M. D.

4/10 1916. (Address) Ames, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ames Idaho — DATE OF BURIAL: 4/12 1916

20. UNDERTAKER: H. Bierbaum — ADDRESS: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 69

Primary Registration District No. 2139

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14403

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Blaine

City of Howe

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl Franklin Catron

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 20 (Day) 1890 (Year)

7. AGE: 25 Yrs. ..... Mos. 3 ds. 14

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School teacher

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Holt Co Missouri

10. NAME OF FATHER: W. S. Catron

11. BIRTHPLACE OF FATHER (State or Country): Holt Co. Missouri

12. MAIDEN NAME OF MOTHER: Mary L. Riley

13. BIRTHPLACE OF MOTHER (State or Country): Holt Co Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lee R. Catron

(Address) Howe, Idaho.

15. Filed 4/3 1916

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/20 1916, to 4/2 1916, that I last saw h— alive on 4/2 1916, and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

4/2 1916 (Address) Arco, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 7 yrs. 6 mos. ..... days

Where was disease contracted if not at place of death? Missouri

Former or usual residence Howe

19. PLACE OF BURIAL OR REMOVAL: Arco Idaho — DATE OF BURIAL: April 5 1916

20. UNDERTAKER: Lee Catron — ADDRESS: Howe, Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 34

County of Elmore

Primary Registration District No. 2020

File No. 14404

City of Bennett Creek (No. ....., ... St.)

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M	W	

6. DATE OF BIRTH: April (Month) 25th (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..5.. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Geo. Vettato

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Edna Lee

13. BIRTHPLACE OF MOTHER (State or Country) Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B.W. Mathis
(Address) Mountain Home Idaho

15.
Filed 4/26 1916 B.W. Mathis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 25th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to 9 a.m. 4/25 1916 that I last saw h.im alive on 9a.m. - 4/25 1916 and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Prematurity -

6 1/2 mos. intrauterine

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B.W. Mathis M. D.

4/26 1916 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bennett Creek	April 26th 1916

20. UNDERTAKER	ADDRESS
Geo. Vettato	Bennett Creek

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & ADRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Elmore

City of Moore Creek

Registration District No. 34

Primary Registration District No. 2020

(No. ....., ... St.)

File No. 14405

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eva Bisnell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): —

6. DATE OF BIRTH. June (Month) 4 (Day) 1905 (Year)

7. AGE: 11 Yrs. 10 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: H N Bisnell

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Lissie Swindstaff

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. N. Bisnell

(Address) of Hell City Idaho

15. Filed April 30th 1916 B O Walter Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ was called to attend deceased ~~from~~ to ~~that I last saw her alive on~~ death occurred ~~at~~ 1916, and that death occured on the date stated above at 1 M. The CAUSE OF DEATH* was as follows: Upon reaching the place where she resided a suspect death was caused by rupture of ~~Tumor~~ (Duration) abscess Yrs. mos. 18 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Travis M. D.

4/30 1916 (Address) Mtn Home, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hell City, Idaho | DATE OF BURIAL: May 1st 1916

20. UNDERTAKER: J. M. Cowen | ADDRESS: Mtn Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Elmore
City of Mtn Home
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34
Primary Registration District No. 2020
(No. .... St.)

File No. 14496
Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Royal Prince Daniel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. June (Month) 18 (Day) 1848 (Year)
7. AGE: 67 Yrs. 9 Mos. 12 ds. IF LESS than 1 day how many .....hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Ill
10. NAME OF FATHER Archibald M. Daniel
11. BIRTHPLACE OF FATHER (State or Country) Ky
12. MAIDEN NAME OF MOTHER Harriet Hudson
13. BIRTHPLACE OF MOTHER (State or Country) Virginia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm M Daniel
(Address) Mountain Idaho
15. Filed April 7th 1916 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 6 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from about Sept 10 1913, to April 6 1916, that I last saw him alive on about Sept 21 1915, and that death occured on the date stated above, at 6.20 A M.
The CAUSE OF DEATH* was as follows:
Cerebral haemorrhage
(Duration) 3 Yrs. 6 mos. ds.
Contributory (Secondary) Second haemorrhage
(Duration Sudden mos. ds.
(Signed) W L Fraser M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Idaho — DATE OF BURIAL: April 8th 1916
20. UNDERTAKER: J M Conway — ADDRESS: Mountain Home Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14408
Registered No. 33

1. PLACE OF DEATH. Registration District No. 96
County of Nez Perce Primary Registration District No. 1009
City of Lewiston (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Roscoe Helm

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 3 (Day) 1916 (Year)

7. AGE: — yrs. 2 mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Baby.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston, Idaho.

10. NAME OF FATHER: Ganadiel S. Helm

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Francis M. Dailey

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. P. Harris,
(Address) Lewiston

15. Filed 5-10-, 1916 L. J. Beckers, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/3/ 1916, to 4/4/ 1916 that I last saw h[illegible] alive on 4/4/ 1916, and that death occurred on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ..... yrs. About 3 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. P. Harris, M. D.

4/4/ 1916 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: May 5- 1916

20. UNDERTAKER: Owen Helm — ADDRESS: Lewiston Orchards

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14409

Registered No. 32

1. PLACE OF DEATH.

Registration District No. 93

Primary Registration District No. 1109

County of Nez Perce

City of Lewiston (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel E Post

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. (Month) Aug (Day) 13 (Year) 1

7. AGE: 81 Yrs. 8 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farming

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER Samuel Post

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred A. Williamson

(Address) Clarkston Wash

15. Filed 5 = 10 = 1916 L. J. Perkins Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Apr. (Day) 2nd (Year) 1916

17. I HEREBY CERTIFY, That I attended deceased from 1912, to Apr. 2nd 1916, that I last saw h[illegible] alive on March 15 1916, and that death occured on the date stated above, at 7-P M.

The CAUSE OF DEATH* was as follows:

Senile Debility

(Duration) many years mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) L. J. Perkins M. D.

4/3 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 191

20. UNDERTAKER: [illegible] Larson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14410

Registered No. 34

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

(No. St. Joseph Hospital St.)

Registration District No. 96

Primary Registration District No. 1009

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Irene Rhoades

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 27 (Day) 1 (Year)

7. AGE: 17 Yrs. 11 Mos. 8 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: scholar

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denver Colo.

10. NAME OF FATHER: Pet. Rhoades

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Blanche Rondall

13. BIRTHPLACE OF MOTHER (State or Country): California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pet. Rhoades

(Address) Lewiston

15. Filed 6-20-1916 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1916, to Apr 5th 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 3-30 A.M.

The CAUSE OF DEATH* was as follows:

Appendicitis with perforation of intestine.

(Duration) Days 1 yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. A. Gourley M. D.

19..... (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cottonwood

DATE OF BURIAL: 191...

20. UNDERTAKER: Leonard

ADDRESS: Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14411

Registered No. 35

1. PLACE OF DEATH.

Registration District No. 9L

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston (No. 1434, Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Caroline M Leitch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Aug (Day) 26 (Year) 1874

7. AGE: 41 Yrs. 8 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER Ephrem Harwood

11. BIRTHPLACE OF FATHER (State or Country) Ind

12. MAIDEN NAME OF MOTHER M-Teedor

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Leitch

(Address) Lewiston Ida

15. Filed 5-10- 1916 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Apr. (Day) 6 1916

17. I HEREBY CERTIFY, That I attended deceased from Jan. 8 1916, to Apr. 6 1916, that I last saw her alive on Apr 5 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Acute pleuro

(Duration) X Yrs. X mos. 8 ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) L. J. Perkins M. D.

4/6 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kooskia Ida — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Lasar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

STHS - YORK CO., PTRS. & BDRS. 24659

L J Perkins

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14412

Registered No. 36

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. St. Joseph Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Emma Ferry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Not known (Month) 1 (Day) (Year)

7. AGE: 44 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ore

10. NAME OF FATHER: Geo Chambers, Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura F. Stephenson

(Address) Webb Bldg

15. Filed 5-10-1916 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4 1916, to April 6 1916, that I last saw h. alive on April 6 1916, and that death occured on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:

Acute Tuberculos Pneumonia

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Edmund Braddock M. D.

Apl 7 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days. In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Tammany — DATE OF BURIAL 191

20. UNDERTAKER — ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BOOKS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of .....

City of .....

Registration District No. 96

Primary Registration District No. 1809

(No. on Street or Ward) (Name of Hospital or Institution)

File No. 14413

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James O'Hara

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	Married

6. DATE OF BIRTH. Sept (Month) 7 (Day) 1 (Year)

7. AGE 63 Yrs. — Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) N. Y.

10. NAME OF FATHER James O'Hara

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Conner

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward O'Hara

(Address) .....

15. Filed 6-10-1916 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6 1916, to Apr 8 1916, that I last saw h... alive on Apr 8 1916, and that death occured on the date stated above, at 9 9 M.

The CAUSE OF DEATH* was as follows:

Obstruction of bowel

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Eule O'Hommel M. D.

19..... (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Orofino Ida — DATE OF BURIAL ..... 191...

20. UNDERTAKER C. J. Vosser — ADDRESS Lewis...

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14414
Registered No. 38

1. PLACE OF DEATH.

County of Nez Perce
City of Lewiston
(No. Hospital St.)

Registration District No. 96
Primary Registration District No. 1009

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas Gilbert Lyle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
June (Month) 20 (Day) 1 (Year)

7. AGE
31 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Chas D Lyle

11. BIRTHPLACE OF FATHER (State or Country): Ken

12. MAIDEN NAME OF MOTHER: M Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. E. Lyle
(Address) Lapwai Ida

15.
Filed 5-10-1916 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8 1916, to April 8 1916, that I last saw h.im alive on April 8 1916, and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Sarcoma of R. Inguinal Glands

(Duration) ..... Yrs. six mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E G Braddock M. D.
April 1916 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Apr 9 1916

20. UNDERTAKER: C J Vassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SOBS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1009
(No. ..... St.)

File No. 14415
Registered No. 89
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Geo. L. Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
(Month) (Day) 1846 (Year)

7. AGE: 70 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: not known
(b) General nature of industry business, or establishment in which employed (or employer): Inmate County Poorfarm

9. BIRTHPLACE (State or Country): not known

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. P. Hanson
(Address) Lewiston Idaho

15.
Filed 6-10-1916 L J Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
4 (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/1/1915, to 4/12/1916, that I last saw h[illegible] alive on 4/12/1916, and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Failing Compensation.

(Duration) Several yrs. ..... mos. ..... ds.
Contributory (Secondary) Contusion
(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) F. P. Hanson M. D.
4/12/1916 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence. .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: 4/12 1916

20. UNDERTAKER: [illegible]
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14416
Registered No. 440

1. PLACE OF DEATH.
County of Nezperce
City of Cul de Sac

Registration District No. 95
Primary Registration District No. 1009
(No. ....., [redacted] St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Jennie [redacted] Kane Faye

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct 20 (Month) (Day) 1866 (Year)

7. AGE: 49 yrs. 5 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: William Kane

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Elizabeth Madill

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno Wright
(Address) Cul de Sac

15.
Filed 5-10-1916 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 17th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15th 1916, to April 17 1916
that I last saw her alive on April 16 1916
and that death occurred on the date stated above, at 1204 M.

The CAUSE OF DEATH* was as follows:
Ruptured Gastric Ulcer
and Peritonitis

..... (Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elsie C. Rogers M. D.
4-17-1916 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cul de Sac
DATE OF BURIAL: 4-18 1916

20. UNDERTAKER: none
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14417

Registered No. 41

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

(No. ....., ... St.)

Registration District No. 96

Primary Registration District No. 1089

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Henry Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. October 25 1886 (Month) (Day) (Year)

7. AGE: 29 Yrs. 5 Mos. 24 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Warehouseman

(b) General nature of industry, business, or establishment in which employed (or employer): at Lewiston Mercantile Co.

9. BIRTHPLACE (State or Country): Straightsville, Conn.

10. NAME OF FATHER: Henry C. Wilson

11. BIRTHPLACE OF FATHER (State or Country): New Marlborough, Mass

12. MAIDEN NAME OF MOTHER: Ellen Mitchell

13. BIRTHPLACE OF MOTHER (State or Country): Conn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Walter H. Wilson

(Address) Lewiston Ida

15. Filed 5-20- 191 6 L. J. Perkins Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 15 1916, to Apr 18 1916, that I last saw him alive on Apr 18 1916, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Abscess

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Cerebritis of Abscess for

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) O. B. Larson M. D.

19..... (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: ..... 191....

20. UNDERTAKER: O Larson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96

Primary Registration District No. 1009

(No. ... St.)

File No. 14418

Registered No. 42

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melissa Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 13 (Day) 1868 (Year)

7. AGE: 48 Yrs. 9 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: John Tripp

11. BIRTHPLACE OF FATHER (State or Country): Pa, Maine

12. MAIDEN NAME OF MOTHER: Barbra Shoop

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C B Nelson

(Address) Lewiston Ida

15. Filed 6-10-1916 E J Perkins Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1916, to April 20 1916, that I last saw h[er] alive on April 19 1916, and that death occured on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) Yrs. 3 mos. 5 ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) Edward S Broadbent M. D.

Apr 20 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 4/22/1916

20. UNDERTAKER: Gleason — ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14419

Registered No. 43

Registration District No. 96

Primary Registration District No. 1019

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

(No. Joseph Boulevard St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Young

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 1 (Day) 70 (Year)

7. AGE: 45 Yrs. 7 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansaw,

10. NAME OF FATHER: — Stallcup

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Young

(Address) Lewiston

15. Filed 5-10-1916 L. J. Kenton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17th 1916, to Apr 26 1916, that I last saw h... alive on Apr 25 1916, and that death occured on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:

Cardiac Dropsy

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary) Chronic Interstitial Nephritis

(Duration 1 yrs. mos. ds.

(Signed) L. E. Carson M. D.

1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 4/23 1916

20. UNDERTAKER: L. E. Carson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

File No. 14420

County of Canyon

City of Caldwell (No. ....., ... St.)

Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Tucker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: (X) May (Month) 20 (Day) 1914 (Year)

7. AGE: 1 Yrs. 11 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Mason E. Tucker

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Martha L. Jay

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mason E Tucker
(Address) Caldwell Idaho

15. Filed 4-29- 1916 John S Meyer Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1916, to April 28 1916, that I last saw him alive on April 28 1916, and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Whooping Cough
Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. J. Miller M. D.

4-29 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greenleaf — DATE OF BURIAL: Apr 30 1916

20. UNDERTAKER: Jackman Care Co — ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14422

Registered No. 34

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

(No. ....., ... St.)

Registration District No. 3

Primary Registration District No. 1005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Brady

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 16 (Day) 1916 (Year)

7. AGE: .....Yrs. .....Mos. 6 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Oral K. Brady

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Ellen Gurwell

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oral K. Brady

(Address) Caldwell, Ida.

15. Filed April 22nd 1916. John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1916, to April 21 1916, that I last saw h.... alive on April 21 1916 and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth.

.....(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. Miller M. D.

4/22 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: April 22 1916

20. UNDERTAKER: Pickham Case Co. ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

47

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3

County of Canyon Primary Registration District No. 2003

City of Caldwell Rural, (No. ..... St.) File No. 14423

If death occurs away from usual residence, give facts called for under special information.

Registered No. 35

2. FULL NAME Maggie Wells

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH. Mar (Month) 23 (Day) 1869 (Year)

7. AGE: 47 Yrs. — Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Pa.

10. NAME OF FATHER William Walker

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Margaret Dunlap

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. Wells
(Address) Caldwell Ida.

15. Filed April 22nd 1916 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 1915, to Apr 20 1916, that I last saw h[illegible] alive on Apr 19 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Cancer Breast

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) T. L. Farmer M. D.
4/21 1916 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 4/22 1916

20. UNDERTAKER: W. E. Dyer — ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PYRS. & BOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 14424
Registered No. 36

1. PLACE OF DEATH.
County of Canyon
City of Caldwell (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Kerby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. December 6 1875 (Month) (Day) 1875 (Year)

7. AGE: 40 Yrs. 4 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Appanoose Co, Iowa

10. NAME OF FATHER Francis M Kerby

11. BIRTHPLACE OF FATHER (State or Country) Putnam Co, Miss Ind

12. MAIDEN NAME OF MOTHER Mary Daily

13. BIRTHPLACE OF MOTHER (State or Country) County Cary, Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J M Kerby
(Address) Caldwell Idaho

15. Filed April 25 1916 John S. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (24)
April 24 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19 1916, to April 24 1916, that I last saw him alive on April 24 1916, and that death occured on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis with
Uraemia
Contributory (Secondary) Rheumatoid Arthritis
(Duration) Final yrs. mos. ds.
(Duration) yrs. mos. ds.
(Signed) J M Cole M. D.
4/24 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Cascade Idaho
DATE OF BURIAL: 4/26 1916

20. UNDERTAKER: W. G. Dyer
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & PUBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. ..... St.)

File No. 14425
Registered No. 37

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Y Mason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.
Jan. (Month) 10 (Day) 1855 (Year)

7. AGE
61 Yrs. 3 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Kentucky

10. NAME OF FATHER
James Mason

11. BIRTHPLACE OF FATHER
(State or Country) Don't Know.

12. MAIDEN NAME OF MOTHER
" "

13. BIRTHPLACE OF MOTHER
(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. H. Mason
(Address) Caldwell Idaho
R.D. #4

15.
Filed 4-26-1916
Jos. S. Meyer
Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 2 1916, to Apr 25 1916, that I last saw h/im alive on Apr 25. 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Tumor Spleen -

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. D. Farren M. D.
4/m 25 1916 (Address) Caldwell Idaho -

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	4-26 1916

20. UNDERTAKER	ADDRESS
W. C. Dyer	Caldwell.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ....., ... St.)

File No. 14426
Registered No. 33

1. PLACE OF DEATH.
County of Canyon
City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thos. W. Beam

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Sept (Month) 14 (Day) 1839 (Year)

7. AGE: 76 Yrs. 7 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: T. Beam.

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania.

12. MAIDEN NAME OF MOTHER: Margaret Deter.

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)
(Address) D. W. Burnes Caldwell Ida.

15. Filed April 16 1916 John S. Mayes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1916, to April 14 1916, that I last saw h— alive on April 14 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Several (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. Nicol M. D.
4-5 1916 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: Apr 17 1916

20. UNDERTAKER: Beckham Case Co. ADDRESS: Caldwell

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14428

Registered No. .....

1. PLACE OF DEATH.

County of Adams

City of Council

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gilbert F. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH. March 8 46
(Month) (Day) (Year)

7. AGE 70 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Unascertained.

11. BIRTHPLACE OF FATHER (State or Country) Unascertained

12. MAIDEN NAME OF MOTHER Unascertained

13. BIRTHPLACE OF MOTHER (State or Country) Unascertained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. H. Mecum M.D.
(Address) Council Ida.

15. Filed 6/11/16 191.... W. H. Mecum Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 11 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.... to ..... 191....,
that I last saw h..... alive on ..... 191....,
and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) W. H. Mecum M. D.

19.... (Address) Council Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Meadows Ida. DATE OF BURIAL 4/12 1916

20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

8V18 - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 53
Primary Registration District No. 2432
File No. 14429
Registered No. 41

1. PLACE OF DEATH
County of Bear Lake
City of Paris (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eliza Perette

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March 11th. 1853 (Month) (Day) (Year)

7. AGE: 63 yrs. 1 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: dont Know

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: dont Know

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Perette
(Address) Paris - Idaho.

15.
Filed 5-10-1916 J. P. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191 , to — 191 , that I last saw h— alive on — 191 , and that death occurred on the date stated above, at 10-30 P.M.

The CAUSE OF DEATH* was as follows:
Paralysis of Heart (?)
Found fell dead; Was not sick or did not complain of being sick one min. before death. yrs. mos. ds.
Contributory (Secondary) Nurse called 10 min after death occured. J. Sutton M.D.
(Duration) yrs. mos. ds.
(Signed) J. Sutton M. D.
May 3 1916 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris Ida — DATE OF BURIAL: May 5 1916

20. UNDERTAKER: Bishop Sutton — ADDRESS: Paris Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Paris
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 253
Primary Registration District No. 2532
(No. ....., ... St.)

File No. 14430
Registered No. 40
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Clisse Letta Huberschmied

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 17 (Day) 1850 (Year)

7. AGE: 66 yrs. 1 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kt. Bern Switzerland

10. NAME OF FATHER: Benedict Schmeizly

11. BIRTHPLACE OF FATHER (State or Country): Kt. Bern Switzerland

12. MAIDEN NAME OF MOTHER: Maria Jess

13. BIRTHPLACE OF MOTHER (State or Country): Kt. Bern Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gottlieb Huberschmied
(Address) Paris Idaho

15. Filed April 24 1916 J. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1915 to April 15 1916, that I last saw her alive on April 15 1916, and that death occurred on the date stated above, at 8:16 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(Duration) 2 yrs. mos. ds.
Contributory (Secondary) Chronic Indigestion
(Duration) 8 yrs. mos. ds.

(Signed) J. Sutton M. D.
April 24 1916 (Address) Paris Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris Ida | DATE OF BURIAL: 4-26 1916

20. UNDERTAKER: Bishop Sutton | ADDRESS: Paris.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD of HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29
Primary Registration District No. 1050
(No. 403, Sherman Ave St.)

File No. 6 1443
Registered No. 27
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret A. Cackerham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 13 (Day) 1915 (Year)

7. AGE: yrs. 1 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: O. O. Cackerham

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Ethel Harrisson

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O O Cackerham
(Address) Post Falls

15. Filed 4-29 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28 1916, to April 29 1916, that I last saw h Er alive on Apr. 29 1916, and that death occurred on the date stated above, at 11 9 M.

The CAUSE OF DEATH* was as follows:
Septic naso-phayngitis with
Septic peritonitis.

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) John O Wood M. D.
Apr. 29 1916 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Post Falls — DATE OF BURIAL: Apr. 30 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14432

Registered No. 23

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D'Alene (No. 403, Sherman St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29

Primary Registration District No. 1050

2. FULL NAME George Harold Krueger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 25 (Day) 1915 (Year)

7. AGE: yrs. 10 mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): C. D'A. Idaho

10. NAME OF FATHER: Conrad Krueger

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Bertha Hoggelke

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Conrad Krueger

(Address) Coeur d'Alene Idaho

15. Filed 4-5 1916 A. Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-4-1916, to 4-4-1916, that I last saw h— alive on 4-4-1916, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Alexander Bacon M. D.

4-6-1916 (Address) 611 Garden ave Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Apr. 6 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6 14433

Registered No. 21

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D'Alene

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2a

Primary Registration District No. 1950

(No. 403, Sherman Ave. St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carl Olson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: March 19 (Month) (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) C D'A, Idaho

10. NAME OF FATHER Carl Olson

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Anna Wold

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl Olson

(Address) Coeur d'Alene Idaho

15.

Filed ..... 191 .....

A. Hughes
Local Registrar

Hughes

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6 1916, to April 7 1916, that I last saw h[im] alive on Apr. 6 1916, and that death occurred on the date stated above, at 4A M.

The CAUSE OF DEATH* was as follows:

Convulsions from intestinal toxaemia

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Mayo M. D.

Apr. 7 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary | DATE OF BURIAL: April 7 1916

20. UNDERTAKER: Cassedy & Nelson | ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 14436
Registered No. 20

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
(No. 102 Sherman Ave St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alta Bragington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	married

6. DATE OF BIRTH.
April 9 1860
(Month) (Day) (Year)

7. AGE
36 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Mich

10. NAME OF FATHER Almond Evans

11. BIRTHPLACE OF FATHER
(State or Country) Mich

12. MAIDEN NAME OF MOTHER Eliza Wolf

13. BIRTHPLACE OF MOTHER
(State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arthur Bragington
(Address) C.d.A.

15.
Filed April 10 1916
O. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 9 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 16 1916, to April 9 1916, that I last saw h[er] alive on Apr. 9 1916, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) Yrs. 1 mos. 20 ds.

Contributory (Secondary) Appendicitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Wynn M. D.
4/10 1916 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem — DATE OF BURIAL: Apr 11 1916

20. UNDERTAKER: S. J. Sears — ADDRESS: C d A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4437

Registered No. 22

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No. 29

Primary Registration District No. 1050

(No. 403 Sherman St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Morris Glosco

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Male	White	Widowed

6. DATE OF BIRTH. Not known

(Month) (Day) (Year)

7. AGE About 70 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Confectionary

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oscar Foster

(Address) Coeur d'Alene

15. Filed April 3 1916. A. Hughes Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 3rd 1916

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-3-1916, to 4-3-1916, that I last saw him alive on 4-3-1916, and that death occured on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Old age & self neglect

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary)

.....(Duration .....yrs. .....mos. .....ds.

(Signed) Alexander Cairns M. D.

4-3-1916 (Address) 611 Garden Ave Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane Wash.	191
20. UNDERTAKER J. C. Kedal	ADDRESS C.D.A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 6 14438
Registered No. 19

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maud Sullivan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March 11 1886 (Month) (Day) (Year)

7. AGE: 30 yrs. ..... mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: C. E. Bobo

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Sullivan
(Address) Coeur d Alene Idaho

15.
Filed Apr 8 1916 A. Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 7 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1916, to Apr 7 1916
that I last saw h- alive on Apr 7 1916
and that death occurred on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:
Heart disease

(Duration) 9 yrs. ..... mos. ..... ds.
Contributory (Secondary) Asthma and Dropsy
(Duration) several years yrs. ..... mos. ..... ds.

(Signed) W. H. Hoeden M. D.
4/7 1916 (Address) Coeur d Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Apr 9 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1070
File No. 6 14439
Registered No. 25

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
(No. 403 Sherman St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm M Rinehard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Sept. (Month) 13 (Day) 1911 (Year)

7. AGE: 4 Yrs. 7 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Robert Rinehard

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Katrin Dawson

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert Rinehard
(Address) Coeur d Alene

15. Filed 4-17 1916
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12 1916, to April 16 1916, that I last saw him alive on April 16 1916, and that death occured on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:
Follicular tonsilitis & naso-pharyngitis

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) John D Wood M. D.
Apr. 17 1916 (Address) Coeur d Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Thomas	Apr 18 1916
20. UNDERTAKER	ADDRESS
S J Quinn	C D A

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4440

Registered No. 30

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 1050

County of Kootenai

City of Coeur d'Alene (No. 703 Sherman St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Elizabeth McKay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 66 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ontario

10. NAME OF FATHER: P. Drouhi

11. BIRTHPLACE OF FATHER (State or Country): Paris France

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Ontario

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno. McKay

(Address) Coeur d'Alene

15. Filed 5-9- 1916 A. Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 7th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1915, to May 7th 1916, that I last saw h-r alive on May 7th 1916, and that death occured on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

Meningitis caused from ear abscess

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Diabetis Mellitus

(Duration 4 yrs. — mos. — ds.

(Signed) Alexander Lee M. D.

5-9- 1916 (Address) 611 Young Ave. C.D.A.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: May 11 1916

20. UNDERTAKER: T. C. Hurd — ADDRESS: C.D.A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6 14111

Registered No. 51

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 1050

County of Kootenai

City of Coeur d'Alene (No. 403 Sherman St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin D. Fake

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 17 (Month) Feb. (Day) 1868 (Year)

7. AGE: 48 Yrs. 1 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Stone Mason
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) South Dakota

10. NAME OF FATHER Thomas Fake

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Mary McDaniels

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lucinda A. Fake
(Address) Coeur d'Alene

15. Filed 5-9 1916 D Hughes Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9th 1916, to May 9. 1916, that I last saw h im alive on May 9. 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Chronic parenchymatous nephritis.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John O Wood M. D.

May 9 1916 (Address) Coeur d'Alene Ida.

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	May 10th 1916
20. UNDERTAKER	ADDRESS
F. C. Kendall	C. D. A.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6442

Registered No. 28

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 1050

County of Kootenai

City of Hayden Lake (No. 403 E Herman St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marmon R. Brown.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 17 (Day) 1913 (Year)

7. AGE: 2 Yrs. 5 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thomas Brown

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Gladys White

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred N White

(Address) Hayden Lake

15. Filed 5-4 1916 N Hughes Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 26654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1916, to May 3, 1916, that I last saw h alive on May 3, 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Drowned

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) John O Wood M. D.

May 3 1916 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairmont Cem Spokane Wash — DATE OF BURIAL: 5-5 1916

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 61443

Registered No. 26

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 405

County of Kootenai

City of Coeur D'Alene (No. 403 Sherman St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hazel Pauline Parker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 25 (Day) 1880 (Year)

7. AGE: 35 yrs. 4 mos. 4 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Weymyer

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. Parker

(Address) Coeur D'Alene Idaho

15. Filed 4-29 1916 J. E. Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) – 29 (Day) – 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 12 1916., to Apr 29 1916., that I last saw her alive on Apr. 29 1916, and that death occurred on the date stated above, at 4 a/M.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus and rectum

(Duration) yrs. 12(?) mos. ds.

Contributory (Secondary)

(Duration) yrs. 1 mos. ds.

(Signed) L. H. Most M. D.

Apr 29 1916 (Address) Coeur d' Alene, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary | DATE OF BURIAL: Apr. 30 1916

20. UNDERTAKER: Cassedy & Nelson | ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 10 14445
Registered No.

1. PLACE OF DEATH. Registration District No. 105
County of Ada Primary Registration District No. 2183
City of Cottonwood (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Clara Schaecher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 18th (Day) 1895 (Year)

7. AGE: 20 yrs. 8 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, professsion, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Christ Schaecher

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Margreth Haus

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Christ Schaecher
(Address) Cottonwood

15. Filed April 2nd 1916 H. Bolade Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28 1916, to April 1st, 1916 that I last saw her alive on April 1st, 1916, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Typhoid fever

..... (Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. V. Turner M. D.
April 2 1916 (Address) Cottonwood, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood, Idaho
DATE OF BURIAL: April 4th 1916

20. UNDERTAKER: None (buried by family)
ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 211.6
File No. 14446
Registered No. 11

1. PLACE OF DEATH.
County of Latah
City of Palouse
(No. ..... St.)*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ardline Carlin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. (8) Feb 17 (Month) (Day) 1915 (Year)

7. AGE: 1 Yrs. 2 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Harry Carlin

11. BIRTHPLACE OF FATHER (State or Country) Minn

12. MAIDEN NAME OF MOTHER Hilda Culver

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hilda Culver
(Address) [redacted] Palouse Idaho

15. Filed May 4, 1916 Edith D Henslee Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 3 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17 1916, to May 3rd 1916, that I last saw her alive on May 3 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Dicentrea and Bronchitis

(Duration) ..... Yrs. ..... mos. 17 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. B. Whitwell M. D.
19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Palouse Cemetery — DATE OF BURIAL 5-4th 1916

20. UNDERTAKER H. C. Dobbs — ADDRESS Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lemhi

City of Salmon

Registration District No. 41

Primary Registration District No. 2116

(No. ....., ... St.)

File No. 14447

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Erma Roxana Mitchell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: June (Month) 28 (Day) 1904 (Year)

7. AGE: 11 Yrs. 10 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: Elmer B. Mitchell

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Lila M. LaMunyon

13. BIRTHPLACE OF MOTHER (State or Country): South Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmer B. Mitchell

(Address) Salmon Idaho

15. Filed May 8, 1916 Earl D. Henderson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 8th 1912; to ..... 191..., that I last saw h[illegible] alive on ..... 191..., and that death occured on the date stated above, at 9:00 A. M.

The CAUSE OF DEATH* was as follows:

Partially from mitral regurgitation as she was under treatment by Physician Secretary at time of death.

(Duration) ..... Yrs. ..... mos. ..... ds.

(Secondary) W. C. Doebler Coroner Salmon Idaho.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Bruton M. D.

5/8 1916 (Address) Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 5-8th 1916

20. UNDERTAKER: W. C. Doebler — ADDRESS: Salmon Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRON - YORK CO., PTGS. & ENGS. 24058

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14448

Registered No. 9

1. PLACE OF DEATH.

Registration District No. 41

Primary Registration District No. 2116

County of Lemhi

City of Gilmore Idaho (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. H. Ruble

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Do not know (Month) (Day) 1 (Year)

7. AGE About 55 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Inventor and Constructor of Placer Mining Elevators

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Do not know

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER (State or Country) Do not know

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. C. Dockler

(Address) Salmon Idaho

15.

Filed May 1, 1916 Edith D Hendren Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 25th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows: Natural Causes due to Stomach trouble

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Dockler Coroner

3rd 1916 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL Eugene Oregon

DATE OF BURIAL ..... 191...

20. UNDERTAKER W. C. Dockler

ADDRESS Salmon Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14449

Registered No. 10

1. PLACE OF DEATH.

County of Lemhi

City of Salmon

(No. ....., ... St.)

Registration District No. 41

Primary Registration District No. 2116

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Henry Poppey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. October (Month) 14 (Day) 1836 (Year)

7. AGE: 79 Yrs. 6 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired Stage Driver

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kiel Holstien

10. NAME OF FATHER Do Not Know

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J A Turnbull

(Address) Salmon Idaho

15.

Filed May 4, 1916 Ethel D Henderson Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 29 (Day) 1916 (Year)

17. I. HEREBY CERTIFY, That I attended deceased from April 26" 1916, to April 29 1916, that I last saw him alive on April 29 1916 and that death occured on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. P. Singleton M. D.

5/4 1916 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery

DATE OF BURIAL: 5-1st 1916

20. UNDERTAKER: W C Dockler

ADDRESS: Salmon Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14450

Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

(No. ....., ... St.)

Registration District No. 19

Primary Registration District No. 2013

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Munall S. Hasty

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May 8 (Month) (Day) 1916 (Year)

7. AGE: ..... Yrs. ..... Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rupert Ida.

10. NAME OF FATHER: Wm Hasty

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Sarah Stevens

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Munall Hasty

(Address) Rupert, Ida.

15. Filed 5-3 1916 E. H. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1916, to May 20 1916, that I last saw h— alive on May 18 1916, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) E. H. Elmore M. D.

4-1 1916 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Ida — DATE OF BURIAL: 4-21 1916

20. UNDERTAKER: None. — ADDRESS

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14451

Registered No. 11

1. PLACE OF DEATH.

County of Minidoka

City of Rupert.

(No. ....., ... St.)

Registration District No. 19

Primary Registration District No. 2015

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Roland Jones.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 29 (Month) (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Minidoka Co.

10. NAME OF FATHER Thos A Jones.

11. BIRTHPLACE OF FATHER (State or Country) Ida.

12. MAIDEN NAME OF MOTHER Minnie Cummings

13. BIRTHPLACE OF MOTHER (State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. A. Jones

(Address) Rupert Ida.

15. Filed 5-10 1916 E. H. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 4 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-27- 1916, to 4-1 1916, that I last saw h[illegible] alive on 4-1 1916 and that death occured on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. H. Elmore M. D.

4-7 1916 (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Idg — DATE OF BURIAL: 4-1 1916

20. UNDERTAKER: None — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGR. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 19

County of Minidoka

Primary Registration District No. 2013

File No. 14452

City of Acequia (No. ..... St.)

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lorys Denney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: April (Month) 30 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 4 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Acequia Idaho

10. NAME OF FATHER Wm Denney.

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Myrtle Pinckney

13. BIRTHPLACE OF MOTHER (State or Country) Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Denney

(Address) Acequia Idaho

15.

Filed 5 – 10 1916 E. H. Edmunds
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 30 1916, to May 3 1916, that I last saw h[illegible] alive on May 3 1916 and that death occurred on the date stated above, at 11½ M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature Birth

..... (Duration) 0 yrs. ..... mos. ..... ds.

(Signed) C. O. Lyons M. D.

0-5 1916 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Idaho — DATE OF BURIAL: 5-4 1916

20. UNDERTAKER: Stone — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14453

Registered No. 79

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 10 D

Primary Registration District No. 3178

County of Madison

City of Lyman (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Franzen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 28 (Day) 1914 (Year)

7. AGE: 2 yrs. 2 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Carl C. Franzen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Edith Arnold

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl C Franzen

(Address) .....

15. Filed 5-1 1916 G L Cook Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1 1916, to to Apr. 29 1916, that I last saw her alive on Apr. 27 1916, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 29 ds.

Contributory (Secondary) Unresolved Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 20 ds.

(Signed) Jos Walker M. D.

19 ..... (Address) Rexburg Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lyman — DATE OF BURIAL: May 1 1916

20. UNDERTAKER: L. A. Williams — ADDRESS: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14454

Registered No. 20

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.)

6. DATE OF BIRTH. April (Month) 20 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ~~44~~ 14 hrs. or ~~45~~ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE Rexburg (State or Country) Madison Idaho

10. NAME OF FATHER John Howard Williams

11. BIRTHPLACE OF FATHER Santa Rosa (State or Country) Sonoma – California

12. MAIDEN NAME OF MOTHER Caroline S. R. Peterson

13. BIRTHPLACE OF MOTHER Woodville (State or Country) Wyrapha, New Zealand

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed 4/22 1916 G G Epe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 20 1916, to Apr. 21 1916, that I last saw him alive on Apr. 20 1916, and that death occured on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows: Unknown

(Duration) ..... Yrs. ..... mos. 15 hrs. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Walker M. D.

19..... (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burton Cemetery	4/22 1916
20. UNDERTAKER None	**ADDRESS**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Archer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 14456
Registered No. 13
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melva M. Martin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Baby

6. DATE OF BIRTH: June (Month) 25 (Day) 1912 (Year)

7. AGE: 3 yrs. 2 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Archer Idaho

10. NAME OF FATHER: John A. Martin

11. BIRTHPLACE OF FATHER (State or Country): Wyoming

12. MAIDEN NAME OF MOTHER: Sarah Jane Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Enoch Martin
(Address) Ridley

15. Filed 3-14 1916 H. G. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 9 (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 1 1916, to Mar 10 1916, that I last saw h[illegible] alive on Mar 10 1916, and that death occurred on the date stated above, at 5 9 M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) Whooping Cough
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joe Walker M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Archer
DATE OF BURIAL: 3/13 1916

20. UNDERTAKER: J. Young
ADDRESS: Ridley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 102

Primary Registration District No. 2178

File No. 14457

Registered No. 76

County of Madison

City of Rexburg (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Phebe A. Stout

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Aug (Month) 19 (Day) 1849 (Year)

7. AGE: 66 yrs. 6 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Ali Smith

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Sarah Gallett.

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Burt Stout
(Address) Rexburg

15. Filed 3/14 1916 G. G. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1916, to Mar. 11 1916, that I last saw h[illegible] alive on Mar 10 1916, and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

~~Lobar Pneumonia~~
Cerebral Hemorrhage

(Duration) 6 yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Marpe M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton | DATE OF BURIAL: 3/16 1916

20. UNDERTAKER: John Phillips | ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 14458
Registered No. 17

1. PLACE OF DEATH.
County of Mad.
City of Rexburg (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Daniel G. Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	White	married

6. DATE OF BIRTH
Feb. (Month) 1 (Day) 1879 (Year)

7. AGE
37 yrs. 1 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Labourer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) America

10. NAME OF FATHER Mons Anderson

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Hannah Gulbranson

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. J. Hanson
(Address) Sugar.

15. Filed 3-21 1916 G G Kepe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10th 1916 to Mar. 21 1916
that I last saw him alive on mar. 21 1916.
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Acute Appendicitus

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Thrupe M. D.
19 (Address) Sugar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rexburg | DATE OF BURIAL 3/23 1916

20. UNDERTAKER John Phillips | ADDRESS Rex.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..., ... St.)

File No. 14459
Registered No. ...
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Gallinger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH (X) April (Month) 26 (Day) 1916 (Year)

7. AGE ... yrs. ... mos. 12 ds.
IF LESS than 1 day how many ... hrs. or ... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ...
(b) General nature of industry business, or establishment in which employed (or employer) ...

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Albert Gallinger Jr.

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Anna Gray

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Gallinger Jr.
(Address) Rexburg

15. Filed 5-8 1916 G Geske Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April May 8 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-7 1916, to 5-7 1916, that I last saw h-r alive on 5-7 1916 and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) G Geske M. D.
19... (Address) ...

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Rexburg | DATE OF BURIAL: May 9 1916

20. UNDERTAKER: L. M. Williams | ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 1976O

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
(No. ....., ... St.)

File No. 14460
Registered No. 14

1. PLACE OF DEATH.

County of .....
City of .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kenneth Dean Vickery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. 1 (Month) 13 (Day) 1916 (Year)

7. AGE: ....Yrs. 1 Mos. 24 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER G. A. Vickery

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary Woodruff

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. A. Vickery
(Address) .....

15. Filed 4-4 1916 W. P. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-3 1916, to 4-4 1916, that I last saw h.. alive on 4-4 1916, and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) .....
.....(Duration) .....yrs.....mos.....ds.

(Signed) E. J. Anderson M. D.
4/4 1916 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho — DATE OF BURIAL: Apr. 4 1916

20. UNDERTAKER: A. G. Corcelle — ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH:
County of Washington
City of Weiser
Registration District No. 86
Primary Registration District No. 1010
(No. ..... St.)
File No. 14461
Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ben F. Eddins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 20 (Day) 1869 (Year)

7. AGE: 47 Yrs. 2 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Probate Judge
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: A H Eddins

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Catherine Vance

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs B. F. Eddins
(Address) Weiser, Idaho

15.
Filed 4-26 1916
W. R. Davidson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/23, 1916, to 4/23, 1916, that I last saw h[illegible] alive on 4/23, 1916, and that death occured on the date stated above at 9:40 A.M.
The CAUSE OF DEATH* was as follows:
Sarcoma of Brain
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... Yrs. ..... mos. ..... ds.
(Signed) W. D. Pinkley M. D.
19..... (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Cemetery — DATE OF BURIAL: 4-25 1916
20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14462

Registered No. 18

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 1010

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Grace Bacus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. Aug (Month) 17 (Day) 1893 (Year)

7. AGE 22 Yrs. 8 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Chas Kiser

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Dora Mallor

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Kiser

(Address) Council Ida.

15. Filed 4-13 1916 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13 1916, to April 13 1916, that I last saw her alive on April 13 1916, and that death occured on the date stated above, at 4a. M.

The CAUSE OF DEATH* was as follows:

Embolism

(Duration) Yrs. 6. mos. ds.

Contributory (Secondary) Endocarditis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James A Young M. D.

April 13 1916 (Address) West Side

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Council Idaho	191...

20. UNDERTAKER Northam & McCown ADDRESS Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14463

Registered No. 15

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 1010

(No. ..... , ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Arthur Dusenberry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 15 (Day) 1893 (Year)

7. AGE: 22 Yrs. 9 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Jesse Dusenberry

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mae Klepper

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse Dusenberry

(Address) Weiser Idaho

15. Filed 4/4/16 191.....

M. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/22 1916, to 4 2 1916, that I last saw him alive on 4-2-1916, and that death occured on the date stated above, at 10 3/4 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) — Yrs. — mos. 10 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ernest O. Fenne, M. D.

4/4 1916 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: 4/4 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 14464
Registered No. 13

1. PLACE OF DEATH.
County of Washington
City of Weiser
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H. Wyatt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH. Oct 9 1840
(Month) (Day) (Year)

7. AGE 75 Yrs. 5 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Engineer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER John J. Wyatt

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Betsey Mayfield

13. BIRTHPLACE OF MOTHER (State or Country) ———

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs L Rigg
(Address) Weiser Idaho

15. Filed April 3rd 1916 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 2nd 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1915, to April 2nd 1916, that I last saw him alive on April 2nd 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
(Duration) Several Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.
4/3/1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Holdredge Nebr — DATE OF BURIAL .....191..

20. UNDERTAKER Thos. McCann — ADDRESS Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 14465
Registered No. 16

1. PLACE OF DEATH.
County of
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lizzie Gross

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feby 19 1 (Month) (Day) (Year)

7. AGE: 6 Yrs. 1 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Russ Gross

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Josie Brown

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M C Brann
(Address) Weiser

15. Filed 4-7 1916 W P Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/5 1916, to 4/5 1916, that I last saw her alive on 4/5 1916 and that death occured on the date stated above, at 12 M

The CAUSE OF DEATH* was as follows:
Burned.

(Duration) ..... Yrs. ..... mos. 6 hours ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Farrell C Grant M. D.
4/6 1916 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mann Creek — DATE OF BURIAL ..... 191...

20. UNDERTAKER: A. J. Cordell — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14466

Registered No. 19

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 2112

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Blanke Gertrude Hiseman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Apr. (Month) 1 (Day) 1883 (Year)

7. AGE 33 Yrs. — Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: John Hackbarth

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Belle Lorentz

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G B Wiseman

(Address) Weiser Idaho

15. Filed 4-20 1916

W. P. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1916, to April 14 1916, that I last saw her alive on April 14 1916, and that death occured on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mel.

Coma

(Duration) Days Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) G M Wakefield M. D.

4/14 1916 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Galloway Cemetery — DATE OF BURIAL: 4/16 1916

20. UNDERTAKER: Northam & McCown — ADDRESS: Weiser Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14467
Registered No. 17

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2162
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy Lothamer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Apr. (Month) 4 (Day) 1916 (Year)

7. AGE: ..... Yrs. ..... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Roy Lothamer

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Dorothy Robertson

13. BIRTHPLACE OF MOTHER (State or Country) Okla

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P. L. Robertson
(Address) Weiser Idaho

15.
Filed 4-8 1916 W. R. Hamilton Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4 1916, to April 6 1916, that I last saw him alive on April 4 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Very much from Birth.
Cerebral Hemmorhage during birth
Heart Failure

(Duration) — Yrs. — mos. ..... ds.

Contributory (Secondary) .....
(Duration — yrs. — mos. ..... ds.

(Signed) James A Young M. D.
April 6 1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Weiser Creek. | DATE OF BURIAL 4/7 1916

20. UNDERTAKER Northcraft & McCann | ADDRESS Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
File No. 14468
Registered No. 38

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adele Riendeau
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	widowed

6. DATE OF BIRTH
oct (Month) ..... (Day) 1837 (Year)

7. AGE
78 yrs. 6 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Michael Lemont

11. BIRTHPLACE OF FATHER (State or Country) canada -

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. H. Riendeau
(Address) Aberdeen, Ida.

15.
Filed ap 30 1916 M. Cameron Timmons
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
april 30 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ap 10 1916, to ap 10 1916, that I last saw h[illegible] alive on ap 10 1916, and that death occurred on the date stated above, at 12 01 M.

The CAUSE OF DEATH* was as follows:
Senile decay -

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) —

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Cameron Timmons M. D.
ap 30 1916 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Aberdeen Ida I.O.O.F. cemetery
DATE OF BURIAL: may 2 1916

20. UNDERTAKER acting M. H. Riendeau
ADDRESS Aberdeen Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14469

Registered No. 3V-

Registration District No. 73

Primary Registration District No. 2120

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo W. Eckenbeck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 6 (Day) 1862 (Year)

7. AGE: 52 Yrs. 1 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisc

10. NAME OF FATHER: Chas. Eckenbeck

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Christena Eastman

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) A J Eckenbeck

15. Filed April 10 1916 Geo Fremond Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gunshot Wound

Suicidal

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) /

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Southard M. D.

4/11 19.. (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: April 15 1916

20. UNDERTAKER: G H Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOES. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14470

Registered No. 30

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls. (No. ....., ... St.)

Registration District No. 73

Primary Registration District No. 2170

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 1 (Day) 1865 (Year)

7. AGE: 51 Yrs. 5 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: John Dueger

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. G. Nelson

(Address) Idaho Falls.

15.

Filed Apr 21 1916

Geo. Townsend
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-10 1916, to 4-15 1916, that I last saw her alive on 4-15 1916, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Adhesions, disease with adhesions in the abdomen

(Duration) ~ Yrs. ~ mos. ~ ds.

Contributory (Secondary) None but above

(Duration) ~ yrs. ~ mos. ~ ds.

(Signed) G. H. Coulthurst M. D.

4/1 1916 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill

DATE OF BURIAL: Apr. 17 1916

20. UNDERTAKER: G. H. Hunt

ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonneville
City of Idaho Falls
(No. ....., ... St.)

Registration District No. 73
Primary Registration District No. 2140

File No. 14471
Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred Willetts

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Aug. (Month) 8 (Day) 1867 (Year)

7. AGE: 49 Yrs. 8 Mo. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mich.

10. NAME OF FATHER: Frank Willetts

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Elizabeth Lambell

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank E. Willetts
(Address) Idaho Falls

15. Filed Apr. 24 1916 Edna Jensen Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:
Gun Shot wound
Self inflicted.

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Dinwoodey M. D.
1916 (Address) Ida Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: April 24 1916

20. UNDERTAKER: G. H. Hunt — ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 210
(No. ....., ... St.)

File No. 11172
Registered No. 37

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marya Brand.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Feb - 20 1863 (Month) (Day) (Year)

7. AGE: 53 Yrs. 1 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Scottland

10. NAME OF FATHER: Robt Montgomery

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Eliza Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emma C. Willis
(Address) Idaho Falls. Ida.

15. Filed Apr. 26 1916 Count Linnard Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 21 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-10 1916, to 4-21 1916, that I last saw h.er alive on April 21 1916, and that death occured on the date stated above, at 2-30 P.M.

The CAUSE OF DEATH* was as follows:

Adenoma of prostate gland

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) ✓

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) T. H. Lunceford M. D.

4-25-16 (Address) Idaho Falls. Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: April 24 1916

20. UNDERTAKER: G. H. Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14473

Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Ida Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2 1 3

(No. ..... St.)

2. FULL NAME Rose Florence Willets

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Feby. (Month) 8 (Day) 1869 (Year)

7. AGE: 47 Yrs. 2 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Thos. Brinson

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: Sarah a Miller

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank E. Willets

(Address) Ida Falls

15. Filed May 2 1916. Corey Arnold Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Homicide - Gun shot wound

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Dunwoody Coroner M. D.

19.... (Address) Ida Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill - Ida Falls — DATE OF BURIAL: 4/28 1916

20. UNDERTAKER: E. E. Dunwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14474

Registered No. 40

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH,
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2117

2. FULL NAME Robert McGavin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 5 (Day) 1843 (Year)

7. AGE: 72 Yrs. 9 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Ranching
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Scotland

10. NAME OF FATHER: Robert McGavin

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Janett Johnston

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anson W. Teall Jr.
(Address) Idaho Falls Ida

15. Filed May 2 1916 E. Swanson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy
no Doctor in attendance
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Dimmock Coroner M. D.
19..... (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Freedom, Wyo. DATE OF BURIAL: 4/23 1916

20. UNDERTAKER: C. E. Dimmock ADDRESS: Idaho Falls

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14475

Registered No. 41

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Ida Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23

Primary Registration District No. 2107

(No. ....., ... St.)

2. FULL NAME Wm J Sell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH.

April (Month) 27 (Day) 1851 (Year)

7. AGE

65 Yrs. X Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER ✓ (State or Country)

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas A Sell

(Address) Pocatello Ida Co

15.

Filed May 1 1916 Compared

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Accidental.
Fell from Auto
4 Miles South of City.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C E Dimwoodey Coroner M.D.

19..... (Address) Ida Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida — DATE OF BURIAL: 4/30/1916

20. UNDERTAKER: C E Dimwoodey — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 14476
Registered No. 25

1. PLACE OF DEATH.
County of Bannock
City of Soda Springs (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maud E Bigler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April 21st 1868 (Month) (Day) (Year)

7. AGE: 47 Yrs. ..... Mos. ..... ds. 20
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Home wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Springville Utah

10. NAME OF FATHER. John C. Witbeck

11. BIRTHPLACE OF FATHER (State or Country) New York State

12. MAIDEN NAME OF MOTHER Emmida Packer

13. BIRTHPLACE OF MOTHER (State or Country) Nauvoo Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Bigler
(Address) Alexander Idaho

15. Filed May 10th 1916 Ellis Rackley Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 10th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20th 1916, to May 10th 1916, that I last saw h[illegible] alive on May 10th 1916, and that death occured on the date stated above, at 8-10 A.M.

The CAUSE OF DEATH* was as follows:
Gall Stones
.....
.....
.....
(Duration) 2 Yrs. 1 mos. 20 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ellis Rackley M. D.
May 4 1916 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos. 3 days
Where was disease contracted if not at place of death? Alexander Ida
Former or usual residence Alexander Ida

19. PLACE OF BURIAL OR REMOVAL: Nephi Utah
DATE OF BURIAL: May 13th 1916

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14478

Registered No. 99

1. PLACE OF DEATH.

Registration District No. 81

Primary Registration District No. 215-8

County of Bonner

City of Priest River (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Morris King Davidson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Jan (Day) 18 (Year) 1836

7. AGE: 80 Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. M. Brown

(Address) Priest River

15. Filed March 21 1916 E D McCarty Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 1916, to March 19 1916, that I last saw him alive on Feb. 26 1916, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Organic heart lesion. Contributory Myocarditis. Chronic interstitial nephritis. Arteriosclerosis

(Duration) Several Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E D McCarty M. D.

3/21 1916 (Address) Priest River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Priest River

DATE OF BURIAL: March 22 1916

20. UNDERTAKER: J E Fleck

ADDRESS: Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonner

City of Priest River

Registration District No. 81

Primary Registration District No. 2138

(No. ....., ... St.)

File No. 1479

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carmen Bombino

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. March (Month) 10 (Day) 1916 (Year)

7. AGE: ..X.. Yrs. ..X.. Mos. ..X.. ds. 3

IF LESS than 1 day how many ..3.. hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Frank Bombino

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER Josephine Cheadica

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Bombino +

(Address) Priest River, Idaho.

15.

Filed March 12 1916

E. S. McCall
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Heart Failure (c

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Knapp, Coroner M. D.

19.... (Address) Hope, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Priest River — DATE OF BURIAL: March 12 1916

20. UNDERTAKER: Mann — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2158
File No. 14480
Registered No. .....

1. PLACE OF DEATH.
County of Bonner
City of Cocur
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rebecca Ann Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Sept (Month) 10 (Day) 1832 (Year)

7. AGE: 83 Yrs. 5 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: ~~Robertson~~ Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Mrs Josephine Conrad

15.
Filed ..... 191.....
E D McCarty
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1916, to March 5 1916, that I last saw her alive on ..... 1916, and that death occured on the date stated above, at 8 45 A.M.

The CAUSE OF DEATH* was as follows:
Apoplexy Cerebral
Hemorrhage
Chronic Nephritis
(Duration) 2 Yrs. 2 mos. ..... ds.
Contributory (Secondary) Senility
Heart Failure (Duration Several hrs. ..... mos. ..... ds.
(Signed) E D McCarty M. D.
3/6 1916 (Address) Forest River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Denver Col — DATE OF BURIAL: Mar 8 1916

20. UNDERTAKER: R H Gray — ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 14482
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Burke.
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Godfrey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May 13 1908
(Month) (Day) (Year)

7. AGE: 7 Yrs. 8 Mos. 13 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burke Ida

10. NAME OF FATHER: M.R. Godfrey

11. BIRTHPLACE OF FATHER (State or Country): Del.

12. MAIDEN NAME OF MOTHER: Mary Emma Richardson Hickes

13. BIRTHPLACE OF MOTHER (State or Country): Ato Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M R Godfrey
(Address) Burke Ida

15.
Filed 4-26 1916.
J. T. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 26 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 6 1916, to April 26 1916, that I last saw him alive on April 26 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Started with Rheumatism Whooping cough + Pleurisy + Consumption
(Duration) Yrs. 1 mos. 6 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. T. Murphy M. D.
April 27 1916 (Address) Burke, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burke Ida. DATE OF BURIAL: April 27 1916

20. UNDERTAKER: Homer B Evans ADDRESS: Burke

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 14483
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME (Name) Lantz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	Single

6. DATE OF BIRTH
Apr. (Month) 8 (Day) 1916 (Year)

7. AGE
0 yrs. 0 mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Miner
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Buhl Ida

10. NAME OF FATHER R. G. Lantz

11. BIRTHPLACE OF FATHER (State or Country) Neb.

12. MAIDEN NAME OF MOTHER Fannie Hahn

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. G. Lantz
(Address) Buhl Idaho.

15.
Filed ..... 191 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Apr. (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 8 1916, to ..... 191..., that I last saw him alive on Apr 8 1916, and that death occurred on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Malformation

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Hawley M. D.
4-8 1916 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl Ida.	Apr 8 1916

20. UNDERTAKER	ADDRESS
H B Evans	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ..... , ... St.)

File No. 14484
Registered No. 28

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Julia Hulet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Baby

6. DATE OF BIRTH. July (Month) 25 (Day) 1915 (Year)

7. AGE: ..... Yrs. 10 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rexburg Idaho

10. NAME OF FATHER: R-R Hulet

11. BIRTHPLACE OF FATHER (State or Country): Kansas -

12. MAIDEN NAME OF MOTHER: Alta Marie Covey

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs J W Covey
(Address) Rexburg

15. Filed 6-9- 1916 G G Espe Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
6 (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-8 1916, to 6-8 1916, that I last saw h- alive on 6-8- 1916 and that death occured on the date stated above, at 5? M.

The CAUSE OF DEATH* was as follows:
Ptomaine Poison
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) G G Espe M. D.
..... 19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL: 6/10 1916

20. UNDERTAKER: Myers — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Plano
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 14485
Registered No. 23
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cecil R. Murdock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Babe

6. DATE OF BIRTH
March (Month) 16 (Day) 1914 (Year)

7. AGE
2 yrs. 1 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Babe
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) ~~Oklahoma~~ Ogden

10. NAME OF FATHER W. T. Murdock

11. BIRTHPLACE OF FATHER (State or Country) Ogden

12. MAIDEN NAME OF MOTHER Mound J Thomas

13. BIRTHPLACE OF MOTHER (State or Country) Ogden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. T. Murdock
(Address) Plano

15. Filed 5/11 1916 G. L. Eshr
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
5 (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1916, to May 8 1916, that I last saw him alive on May 8 1916, and that death occurred on the date stated above, at 8a M.

The CAUSE OF DEATH* was as follows:
Catarrhal Jaundice

(Duration) ..... yrs. 1 mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
19 ..... (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Plano	5/10 1916

20. UNDERTAKER	ADDRESS
J Ryan	Ryan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. .... St.)

File No. 14487
Registered No. 27

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eugene P. Clemmts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH.
Oct (Month) 13 (Day) 1853 (Year)

7. AGE
60 Yrs. 7 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Minnesotta

10. NAME OF FATHER: John F Clemmts

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Margaret Davis

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs E. Clemmts
(Address) Rexburg

15.
Filed 6-5 1916
G L Leaper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
6 (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1915 to June 1916, that I last saw h-- alive on May 1 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) J R Sharpe M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 6/6/16 1916

20. UNDERTAKER: J Rigsmy — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 14488
Registered No. 24
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Merrell R. Hanson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Sept. (Month) 30 (Day) 1897 (Year)

7. AGE: 18 yrs. 7 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labourer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James P. Hanson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Elizabeth Rigby

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E. Hanson
(Address) Rexburg

15. Filed May 13 1916 G. L. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: ~~May~~ ~~Sept.~~ 30 13 1916 ~~1917~~ 191 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9 1916, to May 13 1916, that I last saw ~~him~~ alive on May 12 1916, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 3½ ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph Waeker M. D.
19.... (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: May 15 1916

20. UNDERTAKER: John Phillips — ADDRESS: Rex

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 14489
Registered No. 20

1. PLACE OF DEATH.
County of Madison
City of Independence No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew C. Andersen
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH
Dec (Month) 15 (Day) 1856 (Year)

7. AGE
59 yrs. 5 mos. 10 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Andrew Andersen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maria Andersen
(Address) Independence

15. Filed 5-29 1916 G.L. Esope
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
5 (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1916, to May 26 1916
that I last saw him alive on May 26 1916
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows: 1 a.m.
Labor Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. Draker M. D.
19 .... (Address) Ruby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton
DATE OF BURIAL ..... 191...

20. UNDERTAKER: John Phillips
ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 102
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 14490
Registered No. 26
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lonette Hawley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~. (*Write* the word.): Married

6. DATE OF BIRTH: Sept. 6 1883 (Month) (Day) (Year)

7. AGE: 32 yrs. 8 mos. 24 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Cyrus B. Hawley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Jeanette Lindsay

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs John Buckland
(Address) Ririe Idaho

15. Filed 6-2 1916 G.L. Estes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1916, to June 1 1916, that I last saw h[er] alive on May 31 1916, and that death occurred on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) 0 yrs. 0 mos. 5 ds.

Contributory (Secondary) Bronchial Asthma

(Duration) 6 yrs, mos. ds.

(Signed) Joseph Walker M. D.

6-2 1916 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Archer — DATE OF BURIAL: 6/3 1916

20. ~~UNDERTAKER~~: Weyons — ADDRESS: Ryley

SVMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. IV 14491

Registered No. 7

1. PLACE OF DEATH.

County of Cassia

City of Inland

(No. ....., ... St.)

Registration District No. 170

Primary Registration District No. 2799

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) April (Day) 21 (Year) 1916

7. AGE: ..... Yrs. 1 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Inland Idaho

10. NAME OF FATHER: John V. Carson

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Myrtle Goff

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. V. Carson

(Address) Inland Idaho

15. Filed 5/31 1916 E. P. Johann Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) May (Day) 30 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30 1916, to May 30 1916, that I last saw him alive on May 30 1916, and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Trouble Pertussis Parent claim child was injured May 29-1916 in crossing ditch

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. V. McCoy M. D.

5/31 1916 (Address) Castleford Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Inland Idaho

DATE OF BURIAL: — 191...

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14492

Registered No. 5

1. PLACE OF DEATH.

County of Caribou

City of Island

(No. ....., ... St.)

Registration District No. 130

Primary Registration District No. 2199

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 4 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER James O. Anderson

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Emma Harris

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. V. Nielson

(Address) Oakley Idaho

15. Filed 5/16 1916 E. P. Chaney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1916, to May 15 1916, that I last saw h[illegible] alive on May 15 1916 and that death occured on the date stated above, at 11:46 M.

The CAUSE OF DEATH* was as follows:

Probable Insufficient Closing of Cardiac & Pulmonary Valves

..... (Duration) — Yrs. — mos. — ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. V. Nielson M. D.

5/16 1916 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Island Idaho — DATE OF BURIAL 5/17 1916

20. UNDERTAKER Howard Price — ADDRESS Oakley Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & STNRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 170

County of Cassia

Primary Registration District No. 796

File No. 10 1493

City of Marion

(No. ....., ... St.)

Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anson Raymah Sessions

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. (Month) 28 (Day) 1894 (Year)

7. AGE: 22 Yrs. 3 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Harvey Sessions

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Alice Boysen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. F. Sessions

(Address) Oakley Idaho

15. Filed 6/13/16 E. P. Holmes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...., that I last saw h... alive on ..... 191...., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Probable Acute Dilatation had Aortic lesion for years,

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

6/13/16 (Address) W. F. Sessions Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Marion Idaho

DATE OF BURIAL: 6/15/16

20. UNDERTAKER: James Whitley

ADDRESS: Marion

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTGS. & ENGS. 24659

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cassia
City of Oakley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 170
Primary Registration District No. 2149
(No. ....., ... St.)

File No. V 14194
Registered No. 8
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Theora McMurray

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH
June 11 1911
(Month) (Day) (Year)

7. AGE
4 yrs. 11 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Wilfred C. McMurray

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Rosalia Vilate Grant

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. P. Oldham
(Address) Oakley Idaho

15.
Filed 6/5 1916 E. P. Oldham
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June 5 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1916, to June 4 1916, that I last saw her alive on June 4 1916, and that death occurred on the date stated above, at 5 30 A.M.

The CAUSE OF DEATH* was as follows:
Scarlet fever

(Duration) ... yrs. ... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) E. P. Oldham M. D.
6/5 1916 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Oakley	6/5 1916

20. UNDERTAKER	ADDRESS
John McMurray	Oakley Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 1976O

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia

City of Oakley

Registration District No. 130

Primary Registration District No. 2199

(No. ....., ... St.)

File No. 10 14495

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sena Olive Hansen Harding

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH. May (Month) 17 (Day) 1888 (Year)

7. AGE: 28 Yrs. — Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Andrew J. Hansen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Bengta Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Victor M. Hansen

(Address) Woodson Idaho

15. Filed May 25 1916 E. V. Oham Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1916, to May 24 1916, that I last saw her alive on May 24 1916 and that death occured on the date stated above, at 3.30 P. M.

The CAUSE OF DEATH* was as follows:

Probable Cardiac Embolism metastasis from double Salpingitis Abs. Dolens, probable Infection

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) W. H. Wilson M. D.

19.... (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley — DATE OF BURIAL: 5/26 1916

20. UNDERTAKER: W. R. Lee — ADDRESS: Oakley Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee
City of Riddle
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 44
Primary Registration District No. 212
(No. ..., ... St.)

File No. 19
Registered No. 14497

2. FULL NAME John Lindstrom

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: October (Month) ... (Day) 1856 (Year)

7. AGE: 60 yrs. ... mos. ... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: J Lindstrom

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wilhelm Lindstrom
(Address) Buhl Idaho

15. Filed 5/20 1916 J C Bartlett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1916, to May 20 1916, that I last saw him alive on May 20 1916, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Kick from a horse in the abdomen

(Duration) ... yrs. ... mos. 1 ds.

Contributory (Secondary) Peritonitis & Shock

(Duration) ... yrs. ... mos. 1 ds.

(Signed) J C Bartlett M. D.

5/20 1916 (Address) Brunean Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: to Buhl Idaho — DATE OF BURIAL: May 24 1916

20. UNDERTAKER: F J Johnson — ADDRESS: Buhl Idaho

MARGIN RESERVED FOR BINDING

PRINT PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 44
Primary Registration District No. 2121
File No. 144498
Registered No.

1. PLACE OF DEATH.
County of Owyhee
City of Grandview
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Martin
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 1 (Day) 1870 (Year)

7. AGE: 46 yrs. 0 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: John Martin

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): United States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ellis Martin
(Address) Grandview

15. Filed May 13 1916 J. C. Bartlett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 11 (Day) — 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 — 1916, to May 11 1916, that I last saw h[illegible] alive on May 11 1916, and that death occurred on the date stated above, at 10¢ M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 5 yrs. 6 mos. 20 ds.

Contributory (Secondary) Pulmonary hemorrhage

(Duration) 0 yrs. mos. ds.

(Signed) J. C. Bartlett M. D.

19 (Address) Grandview

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Grandview Idaho — DATE OF BURIAL: May 12 1916

20. UNDERTAKER: L. E. Sears — ADDRESS: Grandview

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Hall City
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58
Primary Registration District No. 2138
(No. ....., ... St.)

File No. 14499
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Geo. Salzman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July 5 1893
(Month) (Day) (Year)

7. AGE: 22 yrs. 10 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep Herder
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Dubrigue Iowa

10. NAME OF FATHER: Henry Joseph Salzman

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Abbie Micka

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Salzman
(Address) Woodstock, Ill.

15.
Filed May 25 1916 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 25 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1916, to May 25 1916
that I last saw h[illegible] alive on May 25 1916
and that death occurred on the date stated above, at 9 15 M.

The CAUSE OF DEATH* was as follows:
Dou[illegible] Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 16 ds.

(Signed) O E Bloom M. D.
5/26 1916 (Address) Hall City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Calvary, Woodstock
DATE OF BURIAL: 5/31 1916

20. UNDERTAKER: J. C. Pierce
ADDRESS: Woodstock Ills.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

S. No. 5. 10M. 6-20-...

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14500

Registered No. .....

1. PLACE OF DEATH.
County of Blaine
City of Corral (No. ....., ... St.)

Registration District No. 38
Primary Registration District No. 2138

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Casper Bach

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March (Month) 1 (Day) 1915 (Year)

7. AGE: 1 yrs. 3 mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: A. L. Bach

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: [illegible] A. Scribner

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Bach
(Address) Corral Ida

15.
Filed 5-4 1916. D O Higgs
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28 1916, to May 3 1916, that I last saw him alive on May 3 1916, and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:
Gastro Enteritis

..... (Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) —

..... (Duration) — yrs. — mos. — ds.

(Signed) D O Higgs M. D.
5-4 1916 (Address) Fairfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Corral Ida
DATE OF BURIAL: 5-4 1916

20. UNDERTAKER: Sig Morrell
ADDRESS: Fairfield

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF [redacted]

[redacted] OF HEALTH
Bureau of Vital Statistics

File No. 14501

Registered No.

1. PLACE OF DEATH.
County of Blaine
City of Soldier
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 228
(No. ..., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Samuel Kersey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 18 (Day) 1863 (Year)

7. AGE: 53 yrs. 4 mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Samuel B Kersey

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jane Powell

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Beck
(Address) Fairfield

15.
Filed 5-26 1916 D P Hoggan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1916, to May 25 1916
that I last saw him alive on May 24 1916,
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Gall Stone Colic

(Duration) — yrs. — mos. 6 ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) A A Tigg M. D.
5-26 1916 (Address) Fairfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Soldier Ida
DATE OF BURIAL: May 26 1916

20. UNDERTAKER: Sig Mavell
ADDRESS: Fairfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14502

Registered No. 32

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 2112

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Woody

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. —

(Month) (Day) (Year)

7. AGE: 25 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER —

(State or Country)

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER —

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A B Seal

(Address) .....

15. Filed 5-8 1916 — W. R. Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 5th 1916

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1915, to May 5th 1916, that I last saw h[illegible] alive on May 5th 1916, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculas Meningitis

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary): Tuberculosis of lungs.

(Duration 1 yrs. — mos. — ds.

(Signed) James A Gowen M. D.

May 6 1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: May 7 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
(No. ..... St.)

File No. 14504
Registered No. 25

1. PLACE OF DEATH.
County of Washington
City of Weiser

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth D Yardley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. 8 (Month) 18 (Day) 1849 (Year)

7. AGE 66 Yrs. 9 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranch Owner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Goodeven

11. BIRTHPLACE OF FATHER (State or Country): [illegible]

12. MAIDEN NAME OF MOTHER: Eliza J Myers

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Florence Benson
(Address)

15. Filed 5-25 1916 W. R. Hamilton, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from no attendance to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Dropped dead - probably some kind of heart trouble

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. M. Walkinshaw M. D.
5/24/1916 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Masonic Cem. Cemetery | DATE OF BURIAL: May 26 1916

20. UNDERTAKER: A. G. Cordelle | ADDRESS: Weiser

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14505

Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 1010

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Shade Fields

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 10 (Day) 1886 (Year)

7. AGE: 30 Yrs. — Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Camp Tender
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: James Fields

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Ema Bradley

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Fields
(Address) The Dalles Ore

15.
Filed ..... 191....
W R Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 25 1916, to May 2 1916, that I last saw him alive on May 1 1916, and that death occured on the date stated above, at 8.30 P.M.

The CAUSE OF DEATH* was as follows:
Thrombosis of mesenteric artery

(Duration) Yrs. ..... mos. 3 ds.

Contributory (Secondary) Rheumatic fever

(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) G M Walkinshaw M. D.
5/2 1916 (Address) Weiser Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho — DATE OF BURIAL: May 3 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1010
Primary Registration District No. 86
(No. ..... St.)

File No. 14506
Registered No. 24

1. PLACE OF DEATH.
County of Washington
City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dovie W. Webb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 22. (Day) 1842 (Year)

7. AGE 74 Yrs. 11 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. E. Salter
(Address) Weiser Ida

15. Filed 5-14 1916 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1916, to May 16 1916, that I last saw him alive on May 16 1916, and that death occured on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Spotted Fever

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) James A Young M. D.

May 16 1916 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Weiser Ida — DATE OF BURIAL 5/17 1916

20. UNDERTAKER Northam & McCann — ADDRESS Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14597

Registered No. 296

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Weiser

(No. ....., ... St.)

Registration District No. 86

Primary Registration District No. 1010

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Upton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 25 (Day) 1841 (Year)

7. AGE: 74 Yrs. 8 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Night Watchman in Store

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mich.

10. NAME OF FATHER: Jos. Upton

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Morehead

(Address) Weiser Idaho

15. Filed 5-29 1916 W. P. Hamilton Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1916, to May 28 1916, that I last saw him alive on May 27 1916, and that death occured on the date stated above, at 10:30 a M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Arteriosclerosis

..... (Duration 5 yrs. — mos. — ds.

(Signed) James A Young M. D.

May 28 1916 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: 5/29 1916

20. UNDERTAKER: Northcraft & McCann — ADDRESS: Weiser Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 14508
Registered No. 23

1. PLACE OF DEATH.
County of Washington
City of Weiser
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Hawes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: ———

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: ———

13. BIRTHPLACE OF MOTHER (State or Country): ———

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. W. Cruikshanks
(Address) Weiser Idaho

15.
Filed 6-7 1916
W. P. Hamilton
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1916, to May 12 1916, that I last saw her alive on May 11 1916, and that death occured on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Arteriosclerosis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo. O. Famsey M. D.
May 12 1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Syracuse. Nebraska
DATE OF BURIAL 191

20. UNDERTAKER: Northam & McCann
ADDRESS: Weiser. Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Stites
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 106
Primary Registration District No. 2184
(No. ....., ... St.)

File No. 14509
Registered No. 39
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Timothy Henry Flynn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: May (Month) 25th (Day) 1851 (Year)

7. AGE: 64 yrs. 11 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Dryfer Flynn

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Margaret Thistletwaite

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary L. Flynn
(Address) Stites

15.
Filed May 10 1916 J.M. Culbertson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1916, to May 5th 1916, that I last saw h. m. alive on May 5th 1916 and that death occurred on the date stated above, at 11:15 M.

The CAUSE OF DEATH* was as follows:
Acute cystitis and prostatitis - plus a condition of general exhaustion
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Enlarged prostate Normal condition
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. W. Wentworth M. D.
May 8 1916 (Address) Stites Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Near Stites
DATE OF BURIAL: May 8 1916
20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

Primary Registration District No. 2184

File No. 14510

Registered No. 40

County of Idaho

City of Kooskia (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Schneider

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 21 (Day) 1868 (Year)

7. AGE: 55 yrs. 7 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Brick maker
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Belleville Illinois

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not obtainable

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John T. Quinlan
(Address) Kooskia Idaho

15. Filed May 12 1916 J.M. Verbeyhuys Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1916., to May 8 1916, that I last saw him alive on May 8 1916, and that death occurred on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows:

Accidental.
Caught in a clay mixer. Fractured ribs & Internal Haemorhage. Severe lacerations (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J.M. Verbeyhuys M. D.
May 10 1916 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kooskia Cemetery — DATE OF BURIAL: May 11 1916

20. UNDERTAKER: Feeney and Merchant — ADDRESS:

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14511
Registered No. 49

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Woodrow Lee Tilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: boy
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 15 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston Idaho

10. NAME OF FATHER: Lee Otis Tilson

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Anna M. Jacobs

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. R. Jacobs
(Address) 1323 - Idaho St.

15.
Filed June 10 - 1916 L. J. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1916, to May 27th 1916
that I last saw him alive on May 26th 1916
and that death occurred on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows:

Underdeveloped at birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. C. Carrigus M. D.
May 27 19 16 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: 5/27 1916

20. UNDERTAKER: Gasser
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14512

Registered No. 50

Registration District No. 9c

Primary Registration District No. 1009

1. PLACE OF DEATH

County of Nezperce

City of Lewiston (No. 207 8th Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. Butler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Aug (Month) 18 (Day) 38 (Year)

7. AGE: 78 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): New Jersey

10. NAME OF FATHER: not known.

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. E. Butler

(Address) Lewiston Ida

15. Filed June 10 1916 — L J Perkins, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1916, to May 29th 1916, that I last saw h[im] alive on Apr 28th 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Pernicious Nephritis complicated

(Duration) Yrs. 3 mos. ... ds.

Contributory (Secondary) ...

(Duration) ... yrs. — mos. — ds.

(Signed) O. C. Pearson M. D.

19 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 5/30 1916

20. UNDERTAKER: O J Pearson — ADDRESS: Lewiston

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 14513
Registered No. 144

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston (No. Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Harlow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1880 (Year)

7. AGE: 36 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John N Alley
(Address) Lewiston Idaho

15. Filed June 10 1916 L. J. Perkins Local Registrar

SYMS - YORK CO., PTRS. & ST'RS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
5 (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-1 1916, to 6-5 1916, that I last saw h— alive on 4-5 1916 and that death occured on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:
Carcinoma of the Stomach

(Duration) 10 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Not known

(Duration ..... yrs. ..... mos. ..... ds.
(Signed) John N Alley M. D.
6-6 1916 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos. 4 days. In the State ..... yrs ..... mos. ..... days
Where was disease contracted if not at place of death? Not known
Former or usual residence Winchester Ida

19. PLACE OF BURIAL OR REMOVAL: Chilton Wis
DATE OF BURIAL 1916

20. UNDERTAKER: D Vassar
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1007
File No. 14515
Registered No. 46

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Philip Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 57 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N. C.

10. NAME OF FATHER: Martin Smith

11. BIRTHPLACE OF FATHER (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Not Known,

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jacob Smith
(Address) .....

15. Filed June 10 - 1916
L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1916, to May 20 1916, that I last saw him alive on May 20 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Cause not ascertained but supposed to be perforation of duodenum from duodenal ulcer.
(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Paul W. Johnson M. D.
May 20 1916 (Address) Clarkston Wn.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pomeroy, Wash. DATE OF BURIAL 191

20. UNDERTAKER: L. Larsen ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1007
File No. 14516
Registered No. 47

1. PLACE OF DEATH.
County of Nezperce
City of Lewiston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy Williamson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Male~~ Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec. (Month) 6 (Day) 1875 (Year)

7. AGE: 41 Yrs. 5 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Marion Truett

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fred D. Williamson
(Address) Clarkston Wash

15. Filed June 20 1916 L. J. Perkins Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1915 to May 21 1916, that I last saw him alive on May 21 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Mitral regurgitation
(Duration) several Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) David H. Rasson M. D.
5/23/16 (Address) Clarkston Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash — DATE OF BURIAL: May 23 1916

20. UNDERTAKER: Henry Merchant — ADDRESS: Clarkston Wash

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14517
Registered No. 48

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 26 21st. St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9c
Primary Registration District No. 1007

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME G. R. Harris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 31 (Day) 1843 (Year)

7. AGE: 74 Yrs. 3 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn

10. NAME OF FATHER: C. T. Harris

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Laura J. Hembry

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. Harris
(Address) Lewiston Ida.

15. Filed June 10 1916
P. J. Leahy
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1916 to May 24 1916, that I last saw him alive on May 24 1916, and that death occured on the date stated above, at 8A M.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage

(Duration) Yrs. mos. 1 ds.
Contributory (Secondary) Arterio Sclerosis
(Duration) Unknown yrs. mos. ds.

(Signed) Edgar R. White M. D.
May 24 1916 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL 191

20. UNDERTAKER: Vassar
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8'
Primary Registration District No. 2158
(No. ..... St.)

File No. 14518
Registered No. 39

1. PLACE OF DEATH.
County of Bonner.
City of Priest River

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charlie Bombino.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. Nov. (Month) 7 (Day) 1881 (Year)

7. AGE: 34 Yrs. 6 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Peter Bombino

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Rosaca Maccarello.

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Angle Maccarello.
(Address) Priest River Ida

15. Filed June 7 1916 — E S McCarty, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1916; to June 7 1916, that I last saw him alive on June 6 1916, and that death occured on the date stated above, at 9:30 a M.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. 18 mos. ..... ds.

(Signed) E S McCarty M. D.
6/7 1916 (Address) Priest River.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Priest River. — DATE OF BURIAL: June 8 1916

20. UNDERTAKER: J E Dufresne — ADDRESS: Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

Primary Registration District No. 2019

File No. 14519

Registered No. 38

County of Boise

City of Horseshoe Bend (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jesse McConnell

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 25 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep owner
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): America.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed June 10 1916 Mary Fitch Deputy.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from never attended 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... P. M.
The CAUSE OF DEATH* was as follows:
Suicide, by shooting.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett — DATE OF BURIAL: May 9 1916

20. UNDERTAKER: Ind none. — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms; so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14520

Registered No. 115

1. PLACE OF DEATH.

County of Cassia

City of Burley

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Hazel Moffett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~. (Write word.): Single

6. DATE OF BIRTH. Dec (Month) 11 (Day) 1901 (Year)

7. AGE: 14 Yrs. 5 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer): At home

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Chas Moffitt

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Martha E Barnes

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Moffett

(Address) View Ida

15.

Filed May 30th 1916 Reg. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 25 1915, to May 29 1916, that I last saw h[illegible] alive on May 29 1916, and that death occured on the date stated above, at 10P. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Trouble

..... (Duration) several Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.

May 29 1916 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: View Ida — DATE OF BURIAL: June 1916

20. UNDERTAKER: Kuwatt — ADDRESS: Burley, Ida

BYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16522

Registered No. 14522

1. PLACE OF DEATH.

Registration District No. 123

Primary Registration District No. 2201

County of Shoshone

City of Stewart (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Apr (Month) 7 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Ed Baskett

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Crawford

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Ed. Baskett

15. Filed 4/25 1916 Geo D Fisher Local Registrar

SYMS - YORK CO., PTRS. & SOLS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 7 1916, to Apr 8 1916, that I last saw him alive on Apr 7 1916, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Premature birth.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. 2 ds.

(Signed) H C Lindsey M. D.

4/26 1916 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg. DATE OF BURIAL: Apr 9 1916

20. UNDERTAKER: M C Thornhill ADDRESS: Kellogg

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
(No. ..... St.)

File No. 14524
Registered No. .....

1. PLACE OF DEATH.
County of Franklin
City of Weston
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lars Marion Rasmussen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 6 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Weston Idaho

10. NAME OF FATHER Martin Rasmussen

11. BIRTHPLACE OF FATHER (State or Country) Weston Idaho

12. MAIDEN NAME OF MOTHER Elsie Fredrickson

13. BIRTHPLACE OF MOTHER (State or Country) Boise Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Martinus Rasmussen
(Address) Weston Ida.

15.
Filed 6-10-1916 D. A. Quelle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1916, to May 26 1916, that I last saw him alive on May 26 1916, and that death occured on the date stated above, at 7.20 P.M.

The CAUSE OF DEATH* was as follows:
Erysipelas

..... (Duration) ..... Yrs. ..... mos. 1/2 ds.

Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. W. Leuck M. D.
5/31 1916 (Address) Franklin Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weston Ida. DATE OF BURIAL: 5/29 1916

20. UNDERTAKER: None. ADDRESS

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 14525
Registered No. 16

1. PLACE OF DEATH.
County of Franklin
City of Preston
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marvin A. Allred

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. aug (Month) 13 (Day) 1849 (Year)

7. AGE: 67 Yrs. 8 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Council Bluffs Iowa

10. NAME OF FATHER: Wm. M. Allred

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Drissa A Bates

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C J Allred
(Address) Preston Idaho

15. Filed b — 10 — 1916 D A Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 5 1916, to May 1st 1916, that I last saw him alive on Apr. 30 1916, and that death occured on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:
Pneumonia - Complicating and Lead Suddenly of Fusting Heart -
(Duration) ..... Yrs. ..... mos. 2 2 ds.
Contributory (Secondary) Arteriosclerosis Chronic of Pneumonia
(Duration ..... yrs. 1 mos. ..... ds.
(Signed) Allen J Cutler M. D.
19..... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris Bear Lake — DATE OF BURIAL: May 5th 1916

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14526
Registered No. 114

1. PLACE OF DEATH.

County of Franklin
City of Weston
(No. ....., ... St.)

Registration District No. 27
Primary Registration District No. 2119

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leo A. Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 26 (Day) 1895 (Year)

7. AGE: 21 Yrs. 7 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Trenton Utah

10. NAME OF FATHER: Fritchuf Jensen

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake City Utah

12. MAIDEN NAME OF MOTHER: Maria Whitney

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harriet-Maria Jensen
(Address) Cornish Utah

15.
Filed ..... 191..... Local Registrar
Dr A Ruth
9 A M

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 7th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7th 1916, to June 7th 1916, that I last saw h[illegible] alive on June 7th 1916, and that death occured on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Perforation of intestines with Hemorrhagic peritonitis and Shock
(Duration) — Yrs. — mos. 2 ds.
Contributory (Secondary) Appendicitis
(Duration) 1 yrs. — mos. — ds.

(Signed) Arthur Hurst M. D.
6-9 1916 (Address) Weston, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cornish Utah — DATE OF BURIAL: June 10 1916

20. UNDERTAKER: W. A. Skedmore — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 11

Primary Registration District No. 2048

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14527

Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Soda Springs

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susie Jane Meyers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. January 1st 1871 (Month) (Day) (Year)

7. AGE: 44 Yrs. 10 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: — Thompson

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alvin Meyers.

(Address) Soda Springs Idaho

15. Filed June 10 1916 Eric Kenley Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1914, to May 20, 1916, that I last saw h[illegible] alive on May 20 1916, and that death occured on the date stated above, at 1.45 P.M.

The CAUSE OF DEATH* was as follows:

Cancer

(Duration) 10 Yrs. — mos. — ds.

Contributory (Secondary) Uremic Hemorrhage

(Duration 10 yrs. mos. ds.

(Signed) Eric Kenley M. D.

May 20 1916 (Address) Soda Springs Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lancaster Wisconsin — DATE OF BURIAL: May 24 1916

20. UNDERTAKER: C. G. Schumacher — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Central
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 82
Primary Registration District No. 3161
(No. ....., ... St.)

File No. 14528
Registered No. 27
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Claus F. Hegstrom

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: July (Month) 27 (Day) 1839 (Year)

7. AGE: 76 yrs. 10 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Anders Hegstrom

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Eva Magretta Hanson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William P. Hegstrom
(Address) Central Idaho

15.
Filed 5-23 1916
R. J. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1916, to May 21 1916, that I last saw h in alive on May 21 1916, and that death occurred on the date stated above, at 12. — M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

..... (Duration) ..... yrs. 4 mos. 4 ds.

(Signed) Russell J. Smith M. D.

5/23 1916 (Address) Bancroft, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Central — DATE OF BURIAL: May 24 1916

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 6048
(No. ....., ... St.)

File No. 14529
Registered No. 26

1. PLACE OF DEATH.
County of Bannock
City of Soda Springs
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Hesse

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR ~~DIVORCED~~. (Write the word.)

6. DATE OF BIRTH.
Dont Know (Month) (Day) 1 (Year)

7. AGE
39 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Barnsmith
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Germany

10. NAME OF FATHER
Dont Know

11. BIRTHPLACE OF FATHER
(State or Country) Dont Know

12. MAIDEN NAME OF MOTHER
Dont Know

13. BIRTHPLACE OF MOTHER
(State or Country) Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ellis Kaseley
(Address) Soda Springs, Ida

15.
Filed June 10, 1916 Ellis Kaseley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 23 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21 1916, to May 23 1916, that I last saw h[illegible] alive on May 23 1916 and that death occured on the date stated above at 1:10 M.
The CAUSE OF DEATH* was as follows:
Cancerous of Stomach

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. 6 mos. ..... ds.
(Signed) Ellis Kaseley M. D.
June 10 1916 (Address) Soda Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mercur — DATE OF BURIAL: ——— 1916

20. UNDERTAKER: D. C. Schumacher — ADDRESS: Soda Springs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D'Alene

(No. 403 Sherman Ave St.)

Registration District No. 29

Primary Registration District No. 1050

File No. 6 14530

Registered No. 133

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Evelin Eachon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 15 (Day) 1916 (Year)

7. AGE: Yrs. 1 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): C. D'A Idaho

10. NAME OF FATHER: Jack Eachon

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: Mary Cooper

13. BIRTHPLACE OF MOTHER (State or Country): C. D'A Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Eachon

(Address)

15. Filed May 21 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21 1916, to May 21 1916, that I last saw h[illegible] alive on May 21 1916, and that death occured on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) [illegible] Yrs. [illegible] mos. [illegible] ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. M. Kaelin M. D.

5/22 1916 (Address) Coeur d Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: May 22 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOOKB. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14532
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Elisabeth Jane Conway

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
Apr. 10 ~~1839~~ 1838
(Month) (Day) (Year)

7. AGE
78 yrs. mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Andrew Myers

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER ~~Crosson~~

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A W Branson
(Address) 818 Garden St Coeur d'Alene Ida

15.
Filed May-10 1916 A Hughes
Local Registrar
By J M S

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 9 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1916, to May 9 1916, that I last saw h[er] alive on May 8 1916 and that death occurred on the date stated above, at 7 20 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J C Myers M. D.
5/10 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary | DATE OF BURIAL: May 12 1916

20. UNDERTAKER: Cassedy & Nelson | ADDRESS: Coeur D'Alene

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 14533
Registered No. 18

1. PLACE OF DEATH.
County of Latah
City of Palouse
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie Johana Prokesch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. May 22nd 1839 (Month) (Day) (Year)

7. AGE: 76 Yrs. 11 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Charles Meltzer

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Marie Johana Meltzer

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph Prokesch
(Address) Palouse Idaho

15. Filed May 12 1916 E D Hamden Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 11th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31 1916, to May 11th 1916, that I last saw her alive on May 11 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease

(Duration) One Yrs. ..... mos. ..... ds.
Contributory (Secondary) Old age
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W. E. Whitwell M. D.
5-12 1916. (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse Cemetery — DATE OF BURIAL: 5-15 1916

20. UNDERTAKER: W. C. Deeds — ADDRESS: Palouse Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 14534
Registered No. 19

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Maroni

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Do not know (Month) (Day) 1 (Year)

7. AGE: about 67 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Quartz & Placer Miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Austria

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER (State or Country) Do not know

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W C Doebler
(Address) Salmon Idaho

15. Filed May 22 1916 Ed Stevenson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 21st 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15th 1916, to May 21 1916, that I last saw h— alive on May 21 1916, and that death occured on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:
Gangrene R Lung

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Wright M. D.
5/22 1916 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: May 24" 1916

20. UNDERTAKER: W C Doebler — ADDRESS: Salmon Ida

SYMS - YORK CO., PTRS. C-10m. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 51
Primary Registration District No. 2130
(No. ... St.)

File No. 3 14535
Registered No. 2
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert E Redington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept 27 1883 (Month) (Day) (Year)

7. AGE: 32 yrs. 8 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: William E Redington

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Lilly R Barton

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lilly B. Redington
(Address) Payette R.D. 1.

15.
Filed June 15th 1916 Crispin Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 13th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Died when I arrived, to June 13 1916, that I last saw h... alive on ... 191..., and that death occurred on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:
Epilepsy - Epileptic Convulsions
which caused on from & probably
suffocation.
(Duration) 20 yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Crispin Wright M. D.
19... (Address) Fruitland, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida
DATE OF BURIAL: 6-15 1916
20. UNDERTAKER: Payette Undertaking Co
ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14536
Registered No. 10

1. PLACE OF DEATH.
County of Latah
City of Bovill
(No. Maxville & Flood St.)
Registration District No. 66
Primary Registration District No. 2146
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. March (Month) 8 (Day) 1913 (Year)
7. AGE: 4 Yrs. — Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: J K Flood
11. BIRTHPLACE OF FATHER (State or Country): N. C.
12. MAIDEN NAME OF MOTHER: Maud M Tallman
13. BIRTHPLACE OF MOTHER (State or Country): Wis.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. K. Flood
(Address)
15. Filed 5/7 1916 J. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) – 7 (Day) – 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 1 – 1916, to May 7 – 1916, that I last saw her alive on May 7 1916, and that death occured on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Typhoid
(Duration) Yrs. mos. 10 ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) F. C. Gibson M. D.
5/7 1916 (Address) Bovill Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Fernwood Idaho
Former or usual residence Fernwood Idaho

19. PLACE OF BURIAL OR REMOVAL: Fernwood — DATE OF BURIAL ..... 191...
20. UNDERTAKER: [illegible] — ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 12-14537
Registered No. .....

1. PLACE OF DEATH.
County of Idaho
City of Canfield
(No. ....., ... St.)
Registration District No. 105
Primary Registration District No. 2183

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith Barnett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 9 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Eugene Barnett

11. BIRTHPLACE OF FATHER (State or Country) N C

12. MAIDEN NAME OF MOTHER Effie Downer

13. BIRTHPLACE OF MOTHER (State or Country) S Dak

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Eugene Barnett
(Address) Canfield

15. Filed May 10 1916 — H B Blake, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from 191 to 191~~ investigated the death of deceased, ~~that I last saw h..... alive~~ on May 10 1916, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Causes (natural) Unknown

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H B Blake M. D.
May 10 1916 (Address) Corner of Ida. C. Kentonville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Downeys Plains Cemetary	May 11 1916
20. UNDERTAKER Eugene Barnett	ADDRESS Canfield, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 105

Primary Registration District No. 2183

File No. 13 14538

County of Idaho

City of Cottonwood (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josephine Shallberger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March (Month) 9 (Day) 1887 (Year)

7. AGE: 29 yrs. 2 mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: None (Sister of Mercy)
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Joseph Shallberger

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Mary Vogler

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mother Superior

(Address) Cottonwood Idaho

15.

Filed May 13 1916 W B Burke
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1915, to ~~May~~ April 25 1916 that I last saw her alive on April 25 1916 and that death occurred on the date stated above, at 5:20 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis.

..... (Duration) / yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ## yrs. ..... mos. ..... ds.

(Signed) W W Burke M. D.

May 12 1916 (Address) Kootenaiville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cemetery of S. Gertrude's Convent

DATE OF BURIAL: May 14 1916

20. UNDERTAKER: Rev. Fr. Daniels, O.S.B.

ADDRESS: Cottonwood

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23

Primary Registration District No. 1017-2017

File No. 14540

County of .....

City of .....

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth E. Perry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. not known (Month) 1 (Day) (Year)

7. AGE: 48 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Fairview, Utah

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jan Green

(Address) Jerome Ida

15.

Filed ..... 191....

E D Piper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 25 1916, to April 9 1916, that I last saw her alive on April 9 191..., and that death occured on the date stated above, at 5:30 P M.

The CAUSE OF DEATH* was as follows:

Rocky Mountain Spotted Fever

(Duration) — Yrs. — mos. 25 ds.

Contributory (Secondary) Chronic Myocarditis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O F Fleming M. D.

19.... (Address) Jerome, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetary — DATE OF BURIAL: April 13 1916

20. UNDERTAKER: Hadenne — ADDRESS: —

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 73

Primary Registration District No. 2107

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14542

Registered No. 73

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bickii Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: (X) Nov. (Month) 25 (Day) 1914 (Year)

7. AGE: 1 Yrs. 16 Mos. 16 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Bonneville

10. NAME OF FATHER: John L Hansen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ethel I Gray

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L Hansen

(Address) .....

15. Filed May 9 1916 Geo Tennis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 2 1916, to Apr. 9 1916, that I last saw h— alive on Apr. 9 1916, and that death occured on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Duration) Yrs. mos. 15 ds.

Contributory (Secondary) Pharyngitis

(Duration) yrs. mos. 7 ds.

(Signed) F. W. Beck M. D.

(Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Idaho — DATE OF BURIAL: April 10 1916.

20. UNDERTAKER: W H Gould — ADDRESS: Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - TOOK CO., PTRS. & BNRS. 24653

Dr Fuller

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2107
File No. 14543
Registered No. 47

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls.
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant -

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. April 23 1916
(Month) (Day) (Year)

7. AGE: 0 Yrs. 0 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Harry Peters

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry Peters
(Address) Idaho Falls.

15.
Filed May 10 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1916, to May 7 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Pneumonia - Bronchs

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. S. Fuller M. D.
5/ 1916 (Address) Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho — DATE OF BURIAL: May 10 1916

20. UNDERTAKER: W. O. Judd — ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STRS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14544
Registered No. 49

1. PLACE OF DEATH.
County of Bonneville
City of Milo
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2107
(No. ....., ... St.)

2. FULL NAME Bird

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~. (*Write* the word.)

6. DATE OF BIRTH: May (Month) 18 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 1 ds.
IF LESS than 1 day *how many* ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry business, or dstablishment in which employed (or employer): None

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Lewis Bird

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Davis

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lewis Bird
(Address) Rigby Ida #2.

15.
Filed May 20 1916 Guy Brumund Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 1916, to May 19 1916, that I last saw h[illegible] alive on May 18 1916, and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Premature

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Cole M. D.
May 19 16 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Milo Idaho — DATE OF BURIAL: May 1916

20. UNDERTAKER: None — ADDRESS: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14545

Registered No. 44

1. PLACE OF DEATH.

County of Bonneville

City of .....

Registration District No. 73

Primary Registration District No. 2150

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Bell Clinton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (X) April (Month) 6 (Day) 1914 (Year)

7. AGE: 0 Yrs. 1 Mos. 7 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Wm Clinton

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Kit Bangert.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Clinton

(Address) Irwin Idaho.

15.

Filed May 15 1916

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h.....alive on ..... 191...,

and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

No medical Attendance

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) Chas Jensen M. D.

5/16 1916 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Irwin Idaho

DATE OF BURIAL: May 14 1916

20. UNDERTAKER: W. H. Sandell

ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14546

Registered No. 10

Registration District No. 73

Primary Registration District No. 2110

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 31 (Day) 1916 (Year)

7. AGE: .....Yrs. .....Mos. .....ds.

IF LESS than 1 day how many 15 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank Bell

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Lena Spear

13. BIRTHPLACE OF MOTHER (State or Country): S. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Bell

(Address) Idaho Falls Idaho

15. Filed June 2 1916 Carl Summers Local Registrar

SYMS-YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1916, to June 1 1916, that I last saw her alive on June 1 1916, and that death occured on the date stated above, at 330 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth - 7 mo.

Congestion

(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary)

(Duration .....yrs. .....mos. .....ds.

(Signed) Carl Summers M. D.

6/2 1916 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: June 2 1916

20. UNDERTAKER: G H Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14547

Registered No. 54

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2107

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Pittenger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Idaho Falls Idaho

15.

Filed 6/4 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

..... (Month) ..... (Day) ..... 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21 1916, to May 24 1916, that I last saw h[illegible] alive on May 24 1916 and that death occured on the date stated above, at ..... P. M.

The CAUSE OF DEATH* was as follows:

Primary Premature Birth - Lungs

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature birth

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Pittenger M. D.

6/4 1916 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: May 24 - 1916

20. UNDERTAKER: [illegible] — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & BOOK. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14548

Registered No. 73

1. PLACE OF DEATH.

Registration District No. 73

Primary Registration District No. 2107

County of Bonneville

City of Ida Falls (No. 4, Pine St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucia Larsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Child

6. DATE OF BIRTH (X)

June (Month) 6 (Day) 1916 (Year)

7. AGE

X yrs. X mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work -

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ammon, Ida

10. NAME OF FATHER Andrew Larsen

11. BIRTHPLACE OF FATHER (State or Country) ~~Denmark~~ Sweden

12. MAIDEN NAME OF MOTHER Eliz. Pugmire

13. BIRTHPLACE OF MOTHER (State or Country) Wyo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mamie Campbell

(Address) R.D. 3 - City

15.

Filed 6/8 1916 Geo Hansard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/6 - 1916, to 6/6 - 1916, that I last saw her alive on 6-6- 1916 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Lack of Vitality

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hollister M. D.

19 ..... (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ammon, Ida — DATE OF BURIAL: 6/7 1916

20. UNDERTAKER: C. C. Dunwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 10760

Dr Hollister.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14549
Registered No. 57

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13
Primary Registration District No. 2170
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth A. Pratt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 15 (Day) 1865 (Year)

7. AGE: 51 yrs. 1 mos. X ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Phillip Currey

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. Pratt
(Address) Dubois, Ida.

15.
Filed June 16 1916 Geo. Jrmand Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1916, to June 14 1916, that I last saw her alive on June 14 1916 and that death occurred on the date stated above, at 11P M.

The CAUSE OF DEATH* was as follows:

Cerebral-Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Jrmand M. D.
6/16 1916 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dubois, Idaho
DATE OF BURIAL: 6/15 1916

20. UNDERTAKER: C. G. Dunwoody
ADDRESS: Ida Falls

SYMS-YORK CO., PTRS. & BDRS. 19760

Dr Kinnaird

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14550

Registered No. 1-4

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 7170

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 40 yrs ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: ?
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) ?

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed June 16 1916 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Suicide
Strychnine Poisoning
Self administered

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Dimmock M.D.

6/16 1916 (Address) Ida Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 6/17 1916

20. UNDERTAKER: C E Dimmock ADDRESS: Ida Falls

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1455
Registered No. 57

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 21-0
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harriet Ann Ritchie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
~~SEX~~ Female	White	Married

6. DATE OF BIRTH: Nov. (Month) 29 (Day) 1863 (Year)

7. AGE: 52 yrs. 6 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Wm Coop

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Martha Hurst

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah E Barlow
(Address) Idaho Falls Ida

15.
Filed July 16 1916 Emy Jamison Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) June (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1916, to June 6 1916, that I last saw her alive on June 6 1916, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Accidental Fall, (with concussion of brain), in Passenger coach
(Duration) Instantly yrs. mos. One ds.
Contributory (Secondary) Apoplexy
(Duration) yrs. mos. One ds.

(Signed) H. W. Pendleton M. D.
19 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iona, Ida
DATE OF BURIAL: 6/9 1916

20. UNDERTAKER: C E Dunwoodey
ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PTRS., BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14552

Registered No. 1-6

1. PLACE OF DEATH.

County of Bannock

City of Ida Falls

(No. ....., ... St.)

Registration District No. 7 3

Primary Registration District No. 2 1 d 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME R. P. Triplett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Black

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ? (Month) (Day) 1 (Year)

7. AGE: about 48 Yrs. Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Virginia

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B E Dunwoody

(Address) Ida Falls

15. Filed 6/6 191 6 Guy Summers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~January~~ May 31 191 6 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

X Pulmonary tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Guy Summers M. D.

6/6 191 6 (Address) Ida Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 6/8 191 6

20. UNDERTAKER: B E Dunwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Fremont

City of Iona

Registration District No. 73

Primary Registration District No. 2170

(No. ....., ... St.)

File No. 14553

Registered No. 1-6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Etta Crofts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 5 (Day) 1876 (Year)

7. AGE: 39 Yrs. 10 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Chancy W. Porter

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Priscilla Strong

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward Crofts
(Address) Iona Idaho

15. Filed May 11 1916 — Casey Mcraid, Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1916, to May 6 1916, that I last saw h[illegible] alive on May 5 1916, and that death occured on the date stated above, at 12-10 A.M.

The CAUSE OF DEATH* was as follows:
Dropsy Caused from poor action of Kidneys and heart
(Duration) 5 Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Frank N. Hilton M. D.
May 7 1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Iona — DATE OF BURIAL: 5/8 1916

20. UNDERTAKER: C C Simmons — ADDRESS: Ida Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
(No. ..... St.)

File No. 14554
Registered No. 92

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Empey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. March (Month) 13 (Day) 1909 (Year)

7. AGE: 7 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ammon, Ida

10. NAME OF FATHER: Harry Empey

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Emma Fields

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. J. Field
(Address) RD 3 - Ida Falls

15. Filed 6/8 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
"Forcibly taken in some unknown manner from the County Highway 4/6/16 about 10 a.m. by unknown assassin with extreme criminal intent who caused her death."
(Duration) " Yrs. mos. ds.
Contributory (Secondary) (Coroners Jury Verdict)
(Duration ... yrs. ... mos. ... ds.
(Signed) C. E. Dunwoody, Coroner
19... (Address) Ida Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ammon Idy. DATE OF BURIAL: 5/17 1916

20. UNDERTAKER: C. E. Dunwoody ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2112
File No. 14555
Registered No. 71

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl Fredrick Everett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. July (Month) 28 (Day) 1887 (Year)

7. AGE 28 Yrs. 9 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farming
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Hooper, Utah

10. NAME OF FATHER James Everett

11. BIRTHPLACE OF FATHER (State or Country) Ogden, Ut.

12. MAIDEN NAME OF MOTHER Mary Jane Maserva

13. BIRTHPLACE OF MOTHER (State or Country) Franklyn Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Everett (By phone)
(Address) Idaho Falls

15. Filed 6/1 1916 Geo. Simmons Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1916, to May 23 1916, that I last saw him alive on May 23 1916, and that death occured on the date stated above, at 12-30 P.M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis &
Mitral Regurgitation
(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Godfrey M. D.
5/27 1916 (Address) Idaho Falls Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rosehill, Idaho Falls	5/25 1916
20. UNDERTAKER C. E. Dinwoodey	ADDRESS Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1032W

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14556

Registered No. 46

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls (No. ..... St.)

Registration District No. 73

Primary Registration District No. 2110

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Lovelace

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. March (Month) 4. (Day) 1880 (Year)

7. AGE 34 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House Wife.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Robert L. Caldwell.

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Hannah Thomas.

13. BIRTHPLACE OF MOTHER (State or Country) North Wales.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert L. Caldwell

(Address) Soda Springs Idaho

15.

Filed May 10 1916

Evan Freeman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1916, to May 8 1916, that I last saw her alive on May 8 1916, and that death occured on the date stated above, at 7A M.

The CAUSE OF DEATH* was as follows:

Injury to head
Homicide

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) S. S. Fuller M. D.

19.... (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Soda Springs Ida. — **DATE OF BURIAL** May 9 1916.

20. UNDERTAKER W. T. Lindsey — **ADDRESS** Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & BKBS. 24052

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2100
File No. 14557
Registered No. 45

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Oneill.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. 45
June (Month) 6 (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Ireland.

10. NAME OF FATHER John Oneill.

11. BIRTHPLACE OF FATHER (State or Country) Ireland.

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Oneill
(Address) Telluride Colo.

15. Filed May 10 1916 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mch (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 18 1916 to Mch 28 1916
that I last saw h[illegible] alive on Mch 27 1916
and that death occured on the date stated above, at 6-9 M.
The CAUSE OF DEATH* was as follows:
Carcinoma Intestines
..... (Duration) Yrs. 5 mos. ..... ds.
Contributory (Secondary) Facy Tubes
..... (Duration yrs. 4 mos. ..... ds.
(Signed) [illegible] M. D.
Mch 28 1916 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Telluride Colorado — DATE OF BURIAL ..... 191...

20. UNDERTAKER W. D. Pond — ADDRESS Idaho Falls Idaho

GYNS - YORK CO., PTGS. & ENGS. 24652

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 73

Primary Registration District No. 2110

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14558

Registered No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Benj. Edwards.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word)
Male	White	Married

6. DATE OF BIRTH. ? 1 (Month) (Day) (Year)

7. AGE 62 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or established in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York.

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. B. Edwards

(Address) Idaho Falls, Ida.

15.

Filed May 9 1916 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 18 1916. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1916, to Mar 18 1916, that I last saw him alive on Mar 18 1916, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ? yrs. ..... mos. ..... ds.

(Signed) C. S. Fuller M. D.

19..... (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Bailey Idaho | DATE OF BURIAL March 1916.

20. UNDERTAKER W. Rands ADDRESS Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 215-0
(No. ....., ... St.)

File No. 14559
Registered No. 42

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jos. Albert Haeys

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. July (Month) 18 (Day) 1912 (Year)

7. AGE: 3 Yrs. 10 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Anaconda, Mont

10. NAME OF FATHER: A C Haeys

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Alice Matthews

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. Matthews
(Address) Ida Falls, Ida

15. Filed May 30 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 5P M.
The CAUSE OF DEATH* was as follows:

Accidental Drowning
2 miles North

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Dinwoodey Coroner
19..... (Address) Ida Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Anaconda Mont — DATE OF BURIAL 191..

20. UNDERTAKER: E E Dinwoodey — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PRS. & STNRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 2168
City of Orofino (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 14560
Registered No. 27
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julian Willoughby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 32 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Rude

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Willoughby
(Address) Pierce Idaho

15. Filed June 1 1916 J. M. Price Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 11 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 27 1916 to May 11 1916
that I last saw her alive on May 10 1916
and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Large pleural effusion
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Nephritis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Ede W Horswell M. D.
5/13 1916 (Address) Orofino, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Orofino — DATE OF BURIAL May 12 1916

20. UNDERTAKER H. E. Stoddard — ADDRESS Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

14561

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Rathdrum

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 2017

(No. ....., ... St.)

File No. [redacted]

Registered No. 501

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rodia C. Hudlow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH

Sept (Month) 15 (Day) 1852 (Year)

7. AGE

64 yrs. 8 mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... House wife

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ind

10. NAME OF FATHER G.W. Hudlow

11. BIRTHPLACE OF FATHER (State or Country) Ind

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rodia Hudlow

(Address) Hayden Lake

15.

Filed 6/10 1916 D.D. Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May (Month) 25th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24th 1916, to May 25. 1916, that I last saw her alive on May 24. 1916, and that death occurred on the date stated above, at 9.45 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) Paralysis

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Frank Wenz M. D.

5/25 1916 (Address) Rathdrum, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rathdrum — DATE OF BURIAL May 26 1916

20. UNDERTAKER Frum — ADDRESS Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 2051

File No. 14562
Registered No. 500
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter E Barnes.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: April (Month) 16 (Day) 1905 (Year)

7. AGE: 10 yrs. 11 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kootenai Co. Idaho.

10. NAME OF FATHER Hezekiah B. Barnes.

11. BIRTHPLACE OF FATHER (State or Country) Coshocton Co. Ohio.

12. MAIDEN NAME OF MOTHER Zola V Berry

13. BIRTHPLACE OF MOTHER (State or Country) Coshocton Co. Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hezekiah B. Barnes
(Address) Rathdrum. Idaho.

Filed 6/10 1916 D S Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 7 (Day) — 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 14 1916, to Apr 7 — 1916, that I last saw h[illegible] alive on Apr 7 — 1916, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Typhoid fever Contd
Abcess

(Duration) ..... yrs. ..... mos. 23 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D S Drennan M. D.
Apl 9 1916 (Address) Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rathdrum	Apr 8 1916
20. UNDERTAKER	ADDRESS
Owstrum	R

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14563

Registered No. 499

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Rathdrum

Registration District No. 12

Primary Registration District No. 2051

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Lewis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M	W	

6. DATE OF BIRTH: Aug. (Month) 17 (Day) 1911 (Year)

7. AGE: 4 yrs. 7 mos. 15 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lewiston Idaho

10. NAME OF FATHER Deane Lewis

11. BIRTHPLACE OF FATHER (State or Country) Grand Rapids Wis

12. MAIDEN NAME OF MOTHER Grace E Lewis

13. BIRTHPLACE OF MOTHER (State or Country) Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Deane Lewis
(Address) Rathdrum

15. Filed 6/10 1916 D D Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 28 1916, to Apr 5 — 1916, that I last saw h[illegible] alive on " 4 1916, and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Pertussis
Gastro Enteritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) D D Brennan M. D.

4/5 1916 (Address) Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rathdrum	4/5 — 1916

20. UNDERTAKER	ADDRESS
A. W. Stone	Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

County of Kootenai
Village
City of Athol

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 17
Primary Registration District No. 2051
(No. ....., ... St.)*

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14564
Registered No. 498

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Cornelius Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced. (Write the Word): Married

6. DATE OF BIRTH. Oct (Month) 9 (Day) 1844 191... (Year)

7. AGE: 71 Yrs 5 Mos 24 ds.
IF LESS than 1 day how many ---- hrs. or ------min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: John Hall ~~Dont Know~~

11. BIRTHPLACE OF FATHER (State or Country): dont know

12. MAIDEN NAME OF MOTHER: Dunstan

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Sarah Hall
(Address) Athol Ida

15.
Filed .....191.. .....
Local Registrar.

Place Where Remains are to be Sent: Remain in Athol
Date of Shipment 191 6

SHIPPING UNDERTAKER
ADDRESS ..... Firm Name Stone

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Apr 2 191 6
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....191..., to .....191...
that I last saw h.....alive on .....191....
and that death occured on the date stated above, at .....M.
The CAUSE OF DEATH was as follows:

Tumor dead and Bad
Glandular ontain

.....(Duration) .....Years .....mos.....ds.
Contributory (Secondary) .....
.....(Duration) .....Years.....mos.....ds.
(Signed) D D Drennan M. D.
.....191... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)
At place 4 yrs In the
of death....yrs....mos....days State ....yrs...mos...days
Where was disease contracted if not at place of death .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Athol
Date of Burial Apr 3 ...191 6

20. UNDERTAKER
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14565
Registered No. 50

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Interstate Mine No. Interstate Mine St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Charles Witkowski
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH: Aug. (Month) 13 (Day) 1880 (Year)
7. AGE: 35 yrs. 9 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Germany
10. NAME OF FATHER: Charles Witkowski
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Henrietta —
13. BIRTHPLACE OF MOTHER (State or Country): Germany
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Charles Witkowski
(Address) Wallace Idaho
15. Filed MAY 26 1916 191 A Leo Lundy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 18 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at 11:30 P.M.
The CAUSE OF DEATH* was as follows:
Fracture Skull due to falling 250 feet down Shaft
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. R. Mowry Coroner
May 25 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible] DATE OF BURIAL: MAY 26 1916
20. UNDERTAKER: Bruce L Moulton ADDRESS: Wallace Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14566
Registered No. 49

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1011
(No. East Wallace St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Pearl O'Neill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 22 (Day) 1904 (Year)

7. AGE: 11 yrs. 10 mos. 28 ds.
IF LESS than 1 day how many.....hrs. or .....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Owen O'Neill

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Clara Rose

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. T. Rose
(Address) Wallace Ida

15.
Filed May 22 1916 F. Leo Lundy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1916, to May 20 1916
that I last saw her alive on May 20 1916
and that death occurred on the date stated above, at 8 A M.
The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) yrs. mos. 8 ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.
(Signed) Wm T. Smyth M. D.
May 22 1916 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: May 22 1916

20. UNDERTAKER: Bruce & Boutet
ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14567

Registered No. 47

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011

(No. Residence Bank St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Katherine Agnes Flick

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 43 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Delaware

10. NAME OF FATHER: Thos. Gorman

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Johannah Burke

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert N. Flick
(Address) Wallace Ida

15. Filed MAY 4 1916 191 ..... F. Leo Zingle Local Registrar

SYMS - YORK CO., PTRS. & BKRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1913, to May 1 1916, that I last saw her alive on May 1 1916, and that death occured on the date stated above, at 10:35 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of the Sigmoid Colon

(Duration) 3 Yrs. 7 mos. ds.

Contributory (Secondary): None

(Duration) yrs. mos. ds.

(Signed) Dr. Howard M. D.

4/4 1916 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mullan Ida	May 5 1916
20. UNDERTAKER	ADDRESS
Ward Hud Co	Wallace Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 20
Primary Registration District No. 1011
File No. 14568
Registered No. 44

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Pennsylvania Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Mueller Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Apr 17 1916
(Month) (Day) 4 (Year)

7. AGE: 1
Yrs. ..... Mos. ..... ds. 4
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wallace

10. NAME OF FATHER: A A Miller

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: Dorothy Devonsher

13. BIRTHPLACE OF MOTHER (State or Country): N. D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A A Miller
(Address) Wallace

15. Filed Apr 27 1916 — F Leo Tingley, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 17 1916, to Apr 27 1916, that I last saw h alive on Apr 20 1916, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) 6 hrs. ..... mos. ..... ds.

(Signed) Dr Mowery M. D.
Apr 25 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence: none

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Apr 22 1916

20. UNDERTAKER: Ward Mud Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1961
(No. Providence Hospital St.)

File No. 14569
Registered No. 40

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Master Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH. (Month): Apr (Day): 17 (Year): 1916
7. AGE: ....Yrs....Mos. 1 ds. IF LESS than 1 day how many....hrs. or ....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Wallace Ida
10. NAME OF FATHER: Alphonse Miller
11. BIRTHPLACE OF FATHER (State or Country): Minn.
12. MAIDEN NAME OF MOTHER: Dorothy Lemaire
13. BIRTHPLACE OF MOTHER (State or Country): North Dakota
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): A. A. Miller
(Address): 920 Resident St Wallace
15. Filed Apr 17 1916 F Leo Jennings Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month): Apr (Day): 18 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr 17 1916, to Apr 18 1916, that I last saw him alive on Apr 17 1916, and that death occured on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Premature birth
(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
(Duration) 1 yrs. mos. ds.
(Signed) D. Mowery M. D.
1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence none

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Apr 19 1916
20. UNDERTAKER: Ward Bros Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14571

Registered No. 47

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 104

(No. Providence Hospital)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Gosselin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (X) (Month) (Day) 1 (Year)

7. AGE: ....Yrs. ....Mos. 4 ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wallace Ida

10. NAME OF FATHER: Joseph Gosselin

11. BIRTHPLACE OF FATHER (State or Country): Quebec

12. MAIDEN NAME OF MOTHER: Beradine Leberick

13. BIRTHPLACE OF MOTHER (State or Country): Ontario

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Gosselin

(Address) Dudesdale 2da

15. Filed Apr 19 1916 Leo Dunfy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 14 1916, to Apr 18 1916, that I last saw him alive on Apr 17 1916, and that death occured on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows: Premature Birth

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) D. H. Mowery M. D.

Apr 18 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death?

Former or usual residence: Wallace 2da

19. PLACE OF BURIAL OR REMOVAL: Wallace 2da — DATE OF BURIAL: 4/19 1916

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace 2da

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 14572
Registered No. 43

1. PLACE OF DEATH.
County of Shoshone
City of Wallace (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thos. Black

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE about. 30 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer on.
(b) General nature of industry, business, or establishment in which employed (or employer): Farm

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. E. Ward
(Address) Wallace 2da

15. Filed Apr 21 1916 F. Leo Lundy Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) ..... (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Accidental = Train
Wreck
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... Yrs. ... mos. ... ds.
(Signed) F. Leo Lundy M. D.
4/21 19... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Mem. | DATE OF BURIAL: Apr 22 1916

20. UNDERTAKER: Ward Und Co | ADDRESS

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14573

Registered No. 37

1. PLACE OF DEATH. Registration District No. 70

County of Shoshone

City of Wallace (No. Providence Hospital St.)

Primary Registration District No. 104

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Frederick Chatham

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 28th (Day) 1876 (Year)

7. AGE: 39 yrs. 9 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: merchant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: John R Chatham

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mrs Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. C. W. Ball
(Address) Pinehurst Ida.

15.
Filed Apr 7 1916
F. Leo Jungy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 5 1916, to April 7 1916, that I last saw him alive on April 6 1916 and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
Left side

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) Pulmonary Tuberculosis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Dr. Thomas M.D.

4/7 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thompson, Mont. DATE OF BURIAL: April 7th 1916.

20. UNDERTAKER: Bruce & Worstell ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14574
Registered No. 38

1. PLACE OF DEATH.
County of Shoshone
City of Wallace (No. Hope Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alex Selby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 35 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Andra Selby

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mrs Alex Selby
(Address): Wallace Shoshone

15.
Filed Apr 10, 1916
H. Leo Snyder
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 5th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl 3rd 1916, to April 5th 1916, that I last saw h alive on Apl 6th 1916, and that death occured on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia.

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) Wm T Snyder M. D.
Apl 5 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence North Yakima

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Apr 9th 1916

20. UNDERTAKER: Ward Lind Co — ADDRESS: Wallace Ida

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14575
Registered No. 39

1. PLACE OF DEATH. Registration District No. 20
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Dora Chandler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Sept 7 (Month) (Day) 1884 (Year)
7. AGE: 31 yrs. 7 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Illinois
10. NAME OF FATHER: James G Cantry
11. BIRTHPLACE OF FATHER (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Sarah Craig
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P A Chandler
(Address) Wallace Ida
15. Filed APR 11 1916 191 H Leo Sunday Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 4 (Month) 9 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 4/3/16 191 ., to 4/9/16 191 that I last saw h[illegible] alive on 4/9/16 191 and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:
Intercular Meningitis
(Duration) yrs. mos. 7 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Frank E Fraser M. D.
4/10/16 19 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Apr 11 1916
20. UNDERTAKER: B L Woodall — ADDRESS: Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1577

Registered No. 33

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 701

(No. Wallace Hospt St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Wasluicke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: ....Yrs....Mos....ds.

IF LESS than 1 day how many....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): unknown

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. E. Ward

(Address) Wallace Ida

15.

Filed April 1916

F. P. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28 1916, to March 31 1916, that I last saw him alive on March 31 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration ....yrs. ....mos. ....ds.

(Signed) Chas. C. Dillman M. D.

March 31 1916 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence: Wallace Ida

19. PLACE OF BURIAL OR REMOVAL: ~~Wallace~~ Pulaski Cem. | DATE OF BURIAL: April 1916

20. UNDERTAKER: Ward Mtg Co | ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14578

Registered No. 34

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011

(No. Providence Hospital)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Larguier

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 70 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Van Derwerken

(Address) 314 Pine St Wallace Ida

15. Filed Apr 7 1916

F. Leo Jungk
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 27 1916, to Mar 29 1916, that I last saw him alive on Mar 29 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows: Shock after operation for Strangulated Hernia

(Duration) ..... Yrs. 2 mos. 4 ds.

Contributory (Secondary): Ingrowing Kidney

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. L. Mowery M. D.

4/4 1916 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Carbonate Canada

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Apr 2nd 1916

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14579
Registered No. 45

1. PLACE OF DEATH.
County of
City of
(No. , St.)
Registration District No. 10
Primary Registration District No. 1011

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herbert Vincent Franey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
6. DATE OF BIRTH: March (Month) 16 (Day) 1916 (Year)
7. AGE: yrs. 1 mos. 10 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*
8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country) Wallace Idaho
10. NAME OF FATHER John Franey
11. BIRTHPLACE OF FATHER (State or Country) Michigan
12. MAIDEN NAME OF MOTHER Mary Miller
13. BIRTHPLACE OF MOTHER (State or Country) Michigan
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Franey
(Address)
15. Filed APR 26 1916 191 — T. Leo Tunney, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr 24 (Month) (Day) 191 6 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr 23 191 6, to Apr 24 191 6 that I last saw h-m alive on Apr 24 191 6 and that death occurred on the date stated above, at 10 P M.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia
(Duration) yrs. mos. 2 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) D S Mowery M. D.
Apr 25 1916 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho Yellowmount Cemetery
DATE OF BURIAL: APR 26 1916 191
20. UNDERTAKER: B Y Marshall
ADDRESS

By Bain

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1017
City of Wallace (No. Providence Hospital)
File No. 14581
Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mordon John Mercer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: February 20 1916 (Month) (Day) (Year)

7. AGE: yrs. 3 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C F Mercer

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Bessie Markle

13. BIRTHPLACE OF MOTHER (State or Country): Mont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C F Mercer
(Address) Gem Ida

15. Filed MAY 5 1916 191.. F Leo Langley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1916, to May 1916 that I last saw h[illegible] alive on May 3 1916 and that death occurred on the date stated above, at ..... M. The CAUSE OF DEATH was as follows:*

Cerebrospinal Meningitis

(Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary): None
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D L Mowery M. D.
4/4 1916 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Missoula Mont. DATE OF BURIAL: May 5 1916

20. UNDERTAKER: L L Worstell ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14582

Registered No. 48

1. PLACE OF DEATH.

Registration District No. 10

Primary Registration District No. 1011

County of Shoshone

City of Wallace (No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Russian Mary Ranev

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: Yrs. 6 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. I. Ranev

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Bertha Bode

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. I. Ranev

(Address) Burke Idaho

15. Filed MAY 15 1916 191.... F Leo Dwyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1916, to May 10 1916, that I last saw her alive on May 10 1916, and that death occured on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) D. Mowry M. D.

May 15 19 16 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: May 16 1916

20. UNDERTAKER: Ward Und Co. — ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14583

Registered No. 51

Registration District No 70

Primary Registration District No 106

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. Hoyt Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Saari

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 1 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jacob Saari

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Mary Merila

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jacob Saari

(Address) 112 Jack Bear

15. Filed May 31 1916 F Leo Tinsley Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1916, to May 29 1916, that I last saw him alive on May 28 1916, and that death occured on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:

Broncho: Pneumonia

(Duration) Yrs. mos. 2 wks

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) [illegible] M. D.

6-2-16 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence: Black Bear Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: May 31 1916

20. UNDERTAKER: Ward Hurd Co — ADDRESS: Wallace Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14584

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho

City of ~~Whitebird~~ Riggins

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Wilson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: X

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 12 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..17.. hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Riggins Ida

10. NAME OF FATHER James Wilson

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Eunice White

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Elmer Hermston

(Address) Riggins Ida

15.

Filed ..... 191.....

W A Foskett
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~no~~ ..... 191....., to ..... 191....., that I last saw h~~e~~ alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Not known

(Duration) ~ Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W A Foskett M. D.

19..... (Address) Whitebird Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riggins Ida

DATE OF BURIAL: April 13 1916

20. UNDERTAKER: —

ADDRESS: —

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14585

Registered No. .....

1. PLACE OF DEATH.

County of .....

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ada Cindry Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Femal

4. COLOR OR RACE: whte

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): X

6. DATE OF BIRTH. May (Month) 16 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... —

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Boles Ida

10. NAME OF FATHER Geo Edgar Wright

11. BIRTHPLACE OF FATHER (State or Country) California

12. MAIDEN NAME OF MOTHER Edna Pearl Wright

13. BIRTHPLACE OF MOTHER (State or Country) Prescott Idah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Edgar Wright

(Address) Boles Ida

15. Filed June 2 1916 W A Tarbett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Hemarhagic Condition

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W A Tarbett M. D.

19.... (Address) Whitebird

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lamfield — DATE OF BURIAL: May 18 1916

20. UNDERTAKER: No — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & sods. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14586
Registered No. .....

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Idaho
City of Whitebird
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nellie Campbell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: f
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. April (Month) 25 (Day) 1872 (Year)
7. AGE: 44 Yrs. 1 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Illinois
10. NAME OF FATHER: Hoffman
11. BIRTHPLACE OF FATHER (State or Country): not known
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (State or Country): —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Campbell
(Address) Whitebird
15.
Filed ..... 191....
W A Foskett
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 4 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916, to June 1 1916,
that I last saw her alive on April 1 1916,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs
(Duration) 5 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W A Foskett M. D.
June 5 1916 (Address) Whitebird Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Whitebird — DATE OF BURIAL: June 5 1916
20. UNDERTAKER: Hancock — ADDRESS: Grangeville

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14587

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ida

City of Joseph

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Seth Zehner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 6 (Day) 1843 (Year)

7. AGE: 70 Yrs. 6 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Isaac Zehner

11. BIRTHPLACE OF FATHER (State or Country) Black Forest Germany

12. MAIDEN NAME OF MOTHER Leah Ryland ~~Mary Nightsmith~~

13. BIRTHPLACE OF MOTHER (State or Country) America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ross Zehner

(Address) Canfield Ida

15.

Filed ..... 191.....

W A Forkett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1915, to Jan 3 1916, that I last saw h~~m~~ alive on Dec 31 1916, and that death occured on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Nephritis with enlarged Prostate

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W A Forkett M. D.

Jan 1916 (Address) Whitebird Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Denver

DATE OF BURIAL: Jan 5 1916

20. UNDERTAKER: Hancock

ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 14590
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho
City of Whitebird

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esther Evelyn Lagbandt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. July (Month) 2 (Day) 1910 (Year)

7. AGE: 5 Yrs. 9 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER Claus Lagbandt

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Evelyn Nichols

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Claus Lagbandt
(Address) Whitebird

15.
Filed ..... 191.....
W. A. Fox
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1916, to June 3 1916,
that I last saw h[illegible] alive on May 21 1916,
and that death occured on the date stated above, at [illegible] M.
The CAUSE OF DEATH* was as follows: Mitral incompetency with dilitation of heart

(Duration) Yrs. 3 mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W A Fox M. D.
June 19 16 (Address) Whitebird Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Whitebird
DATE OF BURIAL ..... 191.....

20. UNDERTAKER: no
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14591
Registered No. .....

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Idaho
City of Whitebird

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Dewitt Daly

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. Jan (Month) ..... (Day) 1850 (Year)
7. AGE: 66 Yrs. 4 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Missouri
10. NAME OF FATHER Joseph Daly
11. BIRTHPLACE OF FATHER (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Rebmilea Darby
13. BIRTHPLACE OF MOTHER (State or Country) Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mellard Daly
(Address) .....
15. Filed June 10 1916 W A Forkett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916, to May 29 1916, that I last saw h. alive on May 28 1916, and that death occured on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Senile Anemia
.....
.....
.....(Duration) ..... Yrs. 6 mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W A Forkett M. D.
May 1916 (Address) Whitebird Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meadian Idaho — DATE OF BURIAL: June 1 1916
20. UNDERTAKER: Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2016
File No. 14592
Registered No. 10

1. PLACE OF DEATH.
County of Lincoln
City or South of Dietrich
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Russel Glen Gage

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 8 (Day) 1861 (Year)

7. AGE: 54 Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: O. W. Gage

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mercy Rozer

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs R. G. Gage
(Address) Dietrich

15. Filed June 17 1916
J. L. Fuller
Local Registrar

SYMS-YORK CO., PTRS. & STNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1915, to June 12 1916, that I last saw him alive on June 1 1916, and that death occured on the date stated above, at 2:40 P.M.

The CAUSE OF DEATH* was as follows:
Cancer Pylorus Stomach

(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Urasmia Contracted Bladder following Operation
6 yrs ago (Duration yrs. mos. ds.

6/14/1916 (Signed) Chas. P. Fuller M. D.
(Address) Shoshone Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: June 16 1916

20. UNDERTAKER: O. J. Brennan — ADDRESS: Shoshone

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9

Registered No. 14593

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lincoln

City of Wardner

District

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Annie Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 28 (Day) 1872 (Year)

7. AGE: 43 Yrs. 10 Mos. 16 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Otto Olson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sanford Anderson

(Address) Morley Michigan

15.

Filed .....191.....

J. L. Fuller
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5/16 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 1st 1916, to May 16 1916, that I last saw h.r alive on May 16 1916, and that death occured on the date stated above, at 5:30 a. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Acute Pneumonia

.....(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Fuller M. D.

19.... (Address) Osborne, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morley Mich — DATE OF BURIAL: 5/21 1916

20. UNDERTAKER: J. Brennan — ADDRESS: Osborne

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14594

Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lincoln

City of South of Richfield (No. ....., ... St.)

Registration District No. 16

Primary Registration District No. 1016

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. G. M Brown

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 19 (Day) 1891 (Year)

7. AGE: 34 Yrs. 9 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: C. C. Montrose

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Hannah Miles

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Grace E Montrose
(Address) Shoshone, Ida.

15. Filed June 3d 1916 J. L. Fuller Local Registrar

SYMS-YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1916, to June 2 1916, that I last saw h.. alive on June 1 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Injury to Cranium, Cervical Vertebrae being pinned under overturned automobile Accidental
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas E. Fuller M. D.
19.... (Address) Shoshone, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone Ida. DATE OF BURIAL: 6/4 1916

20. UNDERTAKER: O'Brennan ADDRESS: Shoshone

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14595

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lincoln

City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 16

Primary Registration District No. 1016

(No. ....., ... St.)

2. FULL NAME Lee Roy Brown

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec 20 1884
(Month) (Day) (Year)

7. AGE: 31 Yrs. 7 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Sam Brown

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alice Brown
(Address) Bellingham Wash

15. Filed May 29 1916

J. K. Fuller
Local Registrar

SYMS - YORK CO., PRTS. & STNRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1916, to May 28 1916, that I last saw h[illegible] alive on May 25 1916, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Spotted Fever

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) No

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

May 29 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? Unknown Shoshone
Former or usual residence None

19. PLACE OF BURIAL OR REMOVAL: Bellingham Wash
DATE OF BURIAL 191

20. UNDERTAKER: O. J. Brannan
ADDRESS: Shoshone

FORM V. S. No. 6-47 M. 1-15-13

CERTIFICATE OF DEATH

Registration District No. 1762

Primary Registration District No. 2273

File No. 1

City of Plummer (No. ..... St.) Registered No. ...

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wan Pavich

If death occurred in hospital, institution give its NAME street and numb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dont know (Month) ..... (Day) ..... 188 (Year)

7. AGE: 28 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Pete Pavich

11. BIRTHPLACE OF FATHER (State or Country): Same

12. MAIDEN NAME OF MOTHER: dont know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph N Pavich
(Address) Elk River Idaho

15.
Filed Jan 19 1916
H G Jaeger
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Not Certain about May 25 (Month) (Day)

17. I HEREBY CERTIFY, That I attended dec ..... 191..., to ..... that I last saw h... alive on ..... and that death occured on the date stated above, at Hos

The CAUSE OF DEATH* was as follows:
By Hanging by Unknown person or p
Verdict of Coroner Jur
(Duration) ..... Yrs. ..... mos.

Contributory (Secondary)
(Duration) ..... Yrs. ..... mos.

(Signed) C J Hinesburg Co
19... (Addr...) St Maries, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CA MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMIC

18. LENGTH OF RESIDENCE (For Hospitals, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. .....
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries Ida — DATE O... 2/7...

20. UNDERTAKER: H G Jaeger — ADDRE... Plum...

N. B.—Every item of information should be carefully supplied. AGE should be recorded EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 46

Primary Registration District No. 2123

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14597

Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Benewah

City of Plummer

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Donald Bell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. (Month) 12 (Day) 1914 (Year)

7. AGE: 1 Yrs. 9 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Plummer Idaho

10. NAME OF FATHER: Jasper N. Bell

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Cathrin Fraser

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. N. Bell

(Address) Plummer Idaho

15.

Filed June 20th 1916

H. L. Jacger
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18th 191..., to June 19 1916, that I last saw him alive on June 18th 1916, and that death occured on the date stated above, at 2. P. M.

The CAUSE OF DEATH* was as follows:

Measles complicated with Croupous Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. P. McCammon M. D.

June 20 1916 (Address) Plummer Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Plummer Idaho

DATE OF BURIAL: June 21st 1916

20. UNDERTAKER: H. L. Jaeger

ADDRESS: Plummer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS (YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14598

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of Rogerson

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Isaac Andrew King

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	married

6. DATE OF BIRTH. Feb. (Month) 8 (Day) 1851 (Year)

7. AGE 65 Yrs. 2 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Rancher

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Frank King

11. BIRTHPLACE OF FATHER (State or Country) don't know

12. MAIDEN NAME OF MOTHER don't know

13. BIRTHPLACE OF MOTHER (State or Country) don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs L. A. King

(Address) Rogerson

15. Filed May 10 1916 W. A. Barrett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1916, to May 5 1916, that I last saw him alive on May 5 1916, and that death occured on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart. (Aortic regurgitation)

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. D. Jolderson M. D.

19.... (Address) Rogerson

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL 191...

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No 6 6
Primary Registration District No 2177
File No. 14599
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of St Anthony
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert Lewis Branson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): infant

6. DATE OF BIRTH. July (Month) 27 (Day) 1914 (Year)

7. AGE: 1 Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Egin Idda

10. NAME OF FATHER: John Albert Branson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Amabell Rawson

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. W. Bonneliers
(Address) St Anthony

15. Filed [illegible] 191 6 W. W. Wood Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 21 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ 4/21 191 6, ~~to~~ ..... ~~191~~ —,
that I last saw h ~~im alive~~ on ..... ~~191~~ —,
and that death occured on the date stated above, at ~~1 p.m.~~ 6 P M.

The CAUSE OF DEATH* was as follows:
Accidental drowning

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) —
(Duration — yrs. — mos. — ds.

(Signed) F. W. Bonneliers M. D.
4/21 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191.....

20. UNDERTAKER None | ADDRESS —

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Fremont — Registration District No. 99

City of Parker — Primary Registration District No. 2177

(No. ....., ... St.)

File No. 14600

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nephi Vest

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 11 (Day) 1916 (Year)

7. AGE: ....Yrs....Mos. 2 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Parker

10. NAME OF FATHER: Edward Vest

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Morley

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ed Vest

(Address) Parker, Idaho

15. Filed May 13 1916 W. Owen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1916, to May 13 1916, that I last saw him alive on May 12 1916, and that death occured on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Malena Neonatorum

.....(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A Montfeed M. D.

May 13 1916 (Address) A Montfeed

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Teton Ida — DATE OF BURIAL: May 14 1916

20. UNDERTAKER: none — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

Registration District No. 99

Primary Registration District No. 2177

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14601

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eva Ann Loomis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Jan (Month) 19 (Day) 1853 (Year)

7. AGE: 63 Yrs. 2 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Dayton Ohio

10. NAME OF FATHER: Alfred Williamson

11. BIRTHPLACE OF FATHER (State or Country): Dont know

12. MAIDEN NAME OF MOTHER: Mary Kugler

13. BIRTHPLACE OF MOTHER (State or Country): Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Loomis

(Address) St Anthony

15. Filed Apr 4 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from notatall 191 , to notatall 191 , that I last saw her alive on Mar. 10 1916, and that death occured on the date stated above, at 10 48 P M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) Yrs. 7 mos. ds.

Contributory (Secondary) Grippe

(Duration yrs. 4 mos. ds.

(Signed) A. Morfield M. D.

Apr 1916 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Anthony Cemetery — DATE OF BURIAL: Apr 4 1916

20. UNDERTAKER: Wm Yager — ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PRS. & SOBS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14602
Registered No.

1. PLACE OF DEATH.
County of Fremont
City of St Anthony
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jean Winegar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Apr (Month) 13 (Day) 1898 (Year)

7. AGE: 18 yrs. ..... mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Parker Ida

10. NAME OF FATHER: Gideon Winegar

11. BIRTHPLACE OF FATHER (State or Country): Mill Creek Utah

12. MAIDEN NAME OF MOTHER: Mary H Mason

13. BIRTHPLACE OF MOTHER (State or Country): Morgan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred H. Mason
(Address) St Anthony Idaho

15. Filed May 1st 1916 W. Elvert Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 27 1916 to Apr 28 1916 that I last saw her alive on Apr 28 1916 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid infection

..... (Duration) ..... yrs. ..... mos. 15 ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A Morefield M. D.

4/30 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parker — DATE OF BURIAL: May 1 1916

20. UNDERTAKER: None — ADDRESS: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14603
Registered No.

1. PLACE OF DEATH.
Registration District No. 99
Primary Registration District No. 2177
County of Fremont
City of St Anthony (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Moore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Sept (Month) 9 (Day) 1840 (Year)

7. AGE: 55 yrs. 7 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Johnstown Pa

10. NAME OF FATHER: Joseph

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER: Lewis

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G B Hawsan
(Address) Waterman Ill

15.
Filed Apr 29 1916 Moorfield Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 22 1916, to Apr 28 1916, that I last saw him alive on Apr 28 1916, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Cerebritis
(Duration) yrs. mos. 6 ds.
Contributory (Secondary) Fracture of fronto temporal region
(Duration) yrs. mos. ds.
(Signed) J Moorfield M. D.
Apr 29 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Waterman Ill
DATE OF BURIAL: 191

20. UNDERTAKER: Wm Yager
ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Mail or Deliver This Certificate to Your Local Registrar. Not to the State Board of Health.

WASHINGTON STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 14604

File No. .....

Registered No. .....

PLACE OF DEATH

County of Benewah

City or Town of De Smet

Registration Dist. No. ..... (No. ....., ... St.; ..... Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information."]

FULL NAME James Milton Sturdevant

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

Personal and Statistical Particulars

3 Sex: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (Write the word):

6 Date of Birth: May (Month) 27 (Day) 1916 (Year)

7 Age: ..... yrs. ..... mos. 5 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 Occupation
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): .....

9 Birthplace (State or country): Idaho

PARENTS

10 Name of Father: J. L. Sturdevant

11 Birthplace of Father (State or country): Missouri

12 Maiden name of Mother: Minnie Garoutte

13 Birthplace of Mother (State or country): Missouri

14 The above is true to the best of my knowledge

(Informant) J. L. Sturdevant

(Address) Tekoa, Wash

15

Filed June 2, 1916 John Tostevin Registrar.

Medical Certificate of Death

16 Date of Death: June (Month) 1 (Day) 1916 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1916, to June 1, 1916, that I last saw him alive on June 1, 1916, and that death occurred, on the date above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy Hemorrhage Cerebral
(Congested Defect)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Nelson, M. D.

June 3, 1916 (Address) Tekoa

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 Length of Residence (For Hospitals, Institutions, Transients, or Recent Residents)

At Place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 Place of ~~Burial or~~ Removal: Tekoa, Wash — Date of Burial: June 3, 1916

20 Undertaker: E. R. Jones — Address: Tekoa

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14605
Registered No. 31

1. PLACE OF DEATH. Registration District No. 43
County of Owyhee Primary Registration District No. 2120
City of Head of Squaw Creek, "The Rocks." (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joe Pineda

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: — — (about) 1891 (Month) (Day) (Year)

7. AGE: 25 yrs (about) mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep herder
(b) General nature of industry business or establishment in which employed (or employer): (for W. M. Kieth)

9. BIRTHPLACE (State or Country): Mexico.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Mexico.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. W. Hicks
(Address) Enterprise or The Rocks Owyhee Co. Idaho

15.
Filed June 18 1916 N. M. Schumpler, M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 14th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Gun-shot wound over left chest, penetrating heart, - no wound of exit - accidentally self inflicted with a Winchester pump shot-gun, (buck shot) - Death must have been instantaneous.
..... (Duration) ..... yrs. ..... mos. ..... ds.
~~Contributory~~ (Secondary) Case personally investigated by the Coroner of Owyhee County.
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) N. M. Schumpler M. D.
June 17. 1916 (Address) Silver City, Ida. Coroner.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: At head of Squaw Creek, Owyhee County (near "The Rocks.")
DATE OF BURIAL: June 17. 1916.
20. UNDERTAKER: W. W. Hicks
ADDRESS: Enterprise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lemhi

City of Volmer

Registration District No. 60

Primary Registration District No. 2129

(No. ....., ... St.)

File No. 14606

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Gregory

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Dec. (Month) 20 (Day) 1908 (Year)

7. AGE: 7 Yrs. 5 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Volmer, Ida.

10. NAME OF FATHER: Austin P. Gregory

11. BIRTHPLACE OF FATHER (State or Country): Monroe Mich

12. MAIDEN NAME OF MOTHER: Ellen Clear

13. BIRTHPLACE OF MOTHER (State or Country): Mazeppa, Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): A. D. Gregory
(Address): Volmer Ida.

15. Filed June 11 1916. R E Davis
Local Registrar

SVMS - YORK CO., PTRS. & SOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1916, to June 11 1916, that I last saw h.r alive on June 11 1916, and that death occured on the date stated above, at 9 a.M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) Yrs. 5 mos. ds.

Contributory (Secondary) Articular rheumatism

(Duration yrs. 6 mos. ds.

(Signed) E J Brush M. D.

6/11 1916 (Address) Volmer Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash. DATE OF BURIAL: 6/13 1916

20. UNDERTAKER: Star Undertaking Co. ADDRESS: Clarkston Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.....
Primary Registration District No.....
File No. 14607
Registered No. 9 (9)

1. PLACE OF DEATH.
County of Lewis
City of Nezperce R.F.D.
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Wapottoto

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: Full blood Nezperce
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Unknown. (Month) (Day) 1 (Year)

7. AGE: 90 over Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Lapwai.

10. NAME OF FATHER: Unknown.

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) X Ellis Kipp
(Address) Nez Perce R.F.D. #3

15. Filed June 3 1916 W.P.E. Dawson Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ did not attend deceased from never 191..., to ..... 191..., that I ~~last~~ saw h.. alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Heart Disease
over
(Duration) 1 Yrs. 2 mos. ..... ds.
Contributory (Secondary) Oedema Lungs.
(Duration ..... yrs. ..... mos. 1/2 ds.

(Signed) R.G. Dawson M. D.
6/5 1916 (Address) Nez Perce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meadow Creek Cemetery (Lapwai) | DATE OF BURIAL: 6/6 1916

20. UNDERTAKER: Ellis Kipp | ADDRESS: Nezperce Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008.
File No. 14608
Registered No. 19

1. PLACE OF DEATH.
County of Canyon
City of Payette
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harriet Drew

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH
Mar (Month) 10 (Day) 1829 (Year)

7. AGE
87 yrs. 2 mos. 26 ds.
IF LESS than 1 day how many .....hrs. or .....mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Thomas Tregoning

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Jury

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary E. Hardy
(Address) .....

15.
Filed June 7 1916 J.C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 11 1915, to June 6 1916, that I last saw h.. alive on June 6 1916 and that death occurred on the date stated above, at 7 45 A. M.

The CAUSE OF DEATH* was as follows:
Senile Paralasis
.....
.....
.....(Duration) — yrs. 8 mos. — ds.

Contributory (Secondary) Senility
.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Ou Barton M. D.
6-6 1916 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence Payette Idaho

19. PLACE OF BURIAL OR REMOVAL D.V. Cem | DATE OF BURIAL June 7 1916

20. UNDERTAKER | ADDRESS Payette

SYMS - YORK CO., PTRS. & BDRS. 19760

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 14609
Registered No. 20

1. PLACE OF DEATH.
County of Canyon
City of Payette (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thos J. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: May (Month) 10 (Day) 1840 (Year)

7. AGE: 76 yrs. 4 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher School
(b) General nature of industry business, or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Job Jones

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Powell

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James O'Hollaren
(Address) Payette Idaho

15.
Filed June 12 1916 J.C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9th 1916, to June 10th 1916, that I last saw h[illegible] alive on June 10th 1916, and that death occurred on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary): Senility
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Crouch M. D.
6/12/1916 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida | DATE OF BURIAL: June 12 1916

20. UNDERTAKER: J.N. Adair | ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008

File No. 14610
Registered No. 21

1. PLACE OF DEATH.
County of Canyon
City of Payette (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sadie E Buller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: March (Month) 1 (Day) 1874 (Year)

7. AGE: 42 yrs. 3 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Michael a Hiller

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Charlotte Brown

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ira. M. Culler
(Address) Payette Ida

15.
Filed June 13 1916 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 1914, to June 10 1916, that I last saw her alive on June 10 1916, and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) Indefinite yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) O. H. Avery M. D.
6/13/1916 (Address) Payette, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: June 13 1916

20. UNDERTAKER: D. McAdair — ADDRESS: Payette Ida

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14611

Registered No. 99

1. PLACE OF DEATH.

County of Canyon

City of Payette

Registration District No. 4

Primary Registration District No. 1008

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Frances Thorp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. July (Month) 26 (Day) 1863 (Year)

7. AGE: 53 Yrs. 7 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Hardin Co. Iowa

10. NAME OF FATHER Henry Mason

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Sarah Ann Brown

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Edgar Peery

(Address) Richland Oregon

15. Filed June 16 1916. J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1916, to June 15 1916, that I last saw h es alive on June 15 1916, and that death occured on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J C Woodward M. D.

6/16 1916 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Richland Oregon — DATE OF BURIAL: June 18 1916

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

SYMS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 14612
Registered No. 23

1. PLACE OF DEATH.
County of Canyon
City of Payette
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice F. Riley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov 17 1889 (Month) (Day) (Year)

7. AGE: 26 yrs. 7 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Neb

10. NAME OF FATHER: John Fowler

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Laura Compton

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. B. Riley
(Address) Payette

15. Filed June 19 1916 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 18 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1916, to June 18 1916, that I last saw h[illegible] alive on June 18 1916, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
Ectopic or Extra-uterine pregnancy "Ruptured"

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James F. McDonald M. D.
6-19 1916 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pioneer Side Cemetery | DATE OF BURIAL: June 20 1916

20. UNDERTAKER: D. H. Cedar | ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 88

Primary Registration District No. 2164

File No. 14615

Registered No. .....

1. PLACE OF DEATH.

County of Washington

City of Cambridge

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gertrude Lucile Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 2 (Day) 1916 (Year)

7. AGE: ..... Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many 1 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Cambridge Ida.

10. NAME OF FATHER: Fred J. Hill

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Alice Hudelson

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred J. Hill

(Address) Cambridge Idaho

15. Filed June 30 1916 O E Schmutz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1916, to May 5 1916, that I last saw h.r alive on May 5 1916, and that death occured on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Immaturity

.....(Duration) ..... Yrs. ..... mos. 3. ds.

Contributory (Secondary) Intestinal malformation

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O E Schmutz M. D.

June 30 1916. (Address) Cambridge Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida. DATE OF BURIAL: May 6 1916

20. UNDERTAKER: Jas Hudelson ADDRESS: Cambridge Id.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS (YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14616

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 32

Primary Registration District No. 2049

County of Benewah

City of St Maries (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Joseph Morris Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 6 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): St Maries

10. NAME OF FATHER: William Joseph Morris

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Garnett Frances Clawson

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm J Morris

(Address) St Maries

15. Filed June 4 1916 W E Smith Local Registrar

SYMS-YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1916, to June 3 1916, that I last saw him alive on June 3 1916, and that death occured on the date stated above, at 7 P.M.

THE CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary): Erysipelas

(Duration ..... yrs. ..... mos. 14 ds.

(Signed) Irene D Clark M. D.

6/4 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: June 4 1916

20. UNDERTAKER: W E Smith — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 82
Primary Registration District No. 2049
(No. .... St.)

File No. 14618
Registered No. .....

1. PLACE OF DEATH.
County of Bonneville
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria Randall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Jan (Month) 17 (Day) 1841 (Year)

7. AGE 75 — 74 Yrs. 5 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Geo. Tiler

11. BIRTHPLACE OF FATHER (State or Country): Holland.

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Ell B Randall
(Address) St Maries

15.
Filed June 3 1916
H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1916, to June 2 1916,
that I last saw her alive on June 2 1916,
and that death occured on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:
Gen Senility
.....(Duration) 5 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Owen D. Platt M. D.
6/3 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: June 4 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14620

Registered No. .....

Registration District No. .....

Primary Registration District No. 2049

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Shoshone

City of Clarkia

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl Frances Brundage

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. (Month) 17 (Day) 1893 (Year)

7. AGE: 24 Yrs. 6 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Ezra L Brundage

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Addie Girard

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Brother Patterson

(Address) Clarkia Ida.

15. Filed June 30 1916

H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1916, to June 29 1916, that I last saw h alive on June 29 1916, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Two Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Asa D Platt M. D.

July 1 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: July 1 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 14621
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Benewah
City of St Maries

2. FULL NAME Aaron A. G. Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 28 (Day) 1853 (Year)

7. AGE: 59 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Car Repairer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Annie Miller
(Address) Malden Wash.

15. Filed June 16 1916 H E Hunt Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1916, to June 15 1916, that I last saw h alive on June 15 1916, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 1 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L L Cornwall M. D.

June 17 1916 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 11 days. In the State ..... yrs. ..... mos. 11 days
Where was disease contracted if not at place of death? Malden Wash.
Former or usual residence Malden Wash

19. PLACE OF BURIAL OR REMOVAL: Rockford Wash. DATE OF BURIAL: June 17 1916

20. UNDERTAKER: H E Hunt ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Aberdeen Bingham
City of Aberdeen (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 116
Primary Registration District No. 2195

File No. 14622
Registered No. 41
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Hiebert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Dec (Month) 30 (Day) 1915 (Year)

7. AGE: — yrs. 5 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Henry C. Hiebert

11. BIRTHPLACE OF FATHER (State or Country) Minnesota

12. MAIDEN NAME OF MOTHER Anna Unruh

13. BIRTHPLACE OF MOTHER (State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. C. Hiebert
(Address) Aberdeen Ida

15. Filed June 16 1916 Frances Kinney Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Enteritis.
No physician in attendance

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mennonite Cemetery — DATE OF BURIAL: June 18 1916

20. UNDERTAKER: actual H. C. Hiebert — ADDRESS: Aberdeen, Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

14623

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1452

Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Boise

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2004

(No. Boise Ida. Ida City Stage St.)

2. FULL NAME Michael Braun.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: Feb. (Month) 2 (Day) 1850 (Year)

7. AGE: 66 Yrs. 5 Mos. [redacted] ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Adam Braun.

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not Obtainable.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. H. Braun.

(Address) Ida. City Stage. Boise Idaho.

15. Filed June 13 1916

E. F. Carlson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/10 1916, to 6/10 1916, that I last saw h..... alive on ..... 191..., and that death occnred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

Chronic Myocarditis

(Duration) Unknown Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) James L. Stewart M. D.

6/13/16 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 6/15 1916

20. UNDERTAKER: Schreiber & Feldmeyer — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004

File No. 14624
Registered No. 36

1. PLACE OF DEATH.
County of Ada
City of near Boise
(No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John St Clair

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June 22 (Month) (Day) 1874 (Year)

7. AGE: 41 Yrs. 11 Mos. 15 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: J. St Clair

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Irma Ball

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. A. St Clair
(Address) Kellogg Ida

15. Filed June 12 1916 E. F. Cater Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/30 1916, to 6/7 1916, that I last saw him alive on 6/3 1916, and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Dysentary.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. 2 mos. 6 ds.

(Signed) Fred A. Dyer M. D.
6/8 1916 (Address) Falk Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: June 11 1916

20. UNDERTAKER: Fry & Summers | ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 3004
File No. 14625
Registered No. 35

1. PLACE OF DEATH.

County of Ada
City of (or town) Boise
(No. Block Rock Dist. St.)
Burns Route

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hattie Clawson Burns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widow

6. DATE OF BIRTH. Dec (Month) 19 (Day) 1836 (Year)

7. AGE: 79 Yrs. 5 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: Allen C. Clawson

11. BIRTHPLACE OF FATHER (State or Country): Ann.

12. MAIDEN NAME OF MOTHER: ~~Hattie~~ not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Ann.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William H. Burns
(Address) Boise Idaho R.F.D. 3

15. Filed 6/10 1916 E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1913, to June 7 1916, that I last saw h[illegible] alive on May 30th 1916, and that death occured on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Stomach trouble

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Bronchial trouble
(Duration 3 yrs. mos. ds.

(Signed) Charles D Reed M.D.
19 (Address) 521 N 10th St Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: June 15 1916

20. UNDERTAKER: Edwin Underwood | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14626

Registered No. 34

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City or Near Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald Lyman Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 3 (Day) 1 (Year)

7. AGE: 46 Yrs. 4 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Hiram Smith

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Telha Harris

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Boise Idaho

(Address) Emma Smith

15. Filed June 6 1916 E. H. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 2 (Day) 16 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30 1916, to June 2 1916, that I last saw h— alive on 2 1916, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Spinal meningitis

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Pleurisy

(Duration) ..... Yrs. ..... mos. 2 ds.

(Signed) R. E. Lantz M. D.

June 7 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: June 6 1916

20. UNDERTAKER: Frey & Summers | ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
(No. Rattle Snake Elmore Co.)

File No. 14627
Registered No. 33

1. PLACE OF DEATH.
County of Elmore
City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April 17 1854 (Month) (Day) (Year)

7. AGE: 62 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ky.

10. NAME OF FATHER: Geo. Green

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mrs. Cook

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Richard M. Green
(Address) Arrow Rock Idaho

15. Filed June 5 1916 E. F. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 4th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1916, to June 4 1916, that I last saw her alive on May 22 1916, and that death occured on the date stated above, at 12.40 A. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of gall bladder

(Duration) 6 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Gall stones
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. V. Talbman M. D.
6/5 1916 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/5 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

BYRD-HOOK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14628

Registered No. 158

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard P. Wilmar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... 1 (Month) (Day) (Year)

7. AGE: about 70 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. J. Davis

(Address) 731 Main Boise Ida

15. Filed 6/29 1916

E. J. Eaton
Local Registrar

BYMS - YORK CO., PTRS. & SORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/9 1916, to 6/28 1916, that I last saw h[illegible] alive on 6/27 1916, and that death occured on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Organic heart

Shock

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cerebral hemorrhage

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. H. Falk M. D.

6/29 19 16 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Idaho City Ida

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/30 1916

20. UNDERTAKER: Schreiber & Lieuallen — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 401 S 3 St.)

File No. 14629

Registered No. 157

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Orando Campbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan 11 (Month) 1 (Day) 831 (Year)

7. AGE 15 Yrs. 4 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER William R. Campbell

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Alice Bailey

13. BIRTHPLACE OF MOTHER (State or Country) Rhode Island

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H E Campbell
(Address) 111 So 10th St

15. Filed 6/27 1916

E. Mann
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 26 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1916, to June 26 1916, that I last saw h... alive on June 26 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Chronic Brights disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jno Calvert M. D.

6/27 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: June 28 1916

20. UNDERTAKER: Gray Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 14630
Registered No. 154

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 110, East Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hiram Smith

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. April 4 (Month) (Day) 1830 (Year)

7. AGE: 86 Yrs. 2 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Millwright
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emma Smith
(Address) Boise R 5

15. Filed June 27 1916 E. J. Eaton Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1916, to June 23 1916, that I last saw h— alive on June 23 1916, and that death occured on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

1. Pneumonia
2. Senility

(Duration) Yrs. mos. 9 ds.

Contributory (Secondary): Senility

(Duration) Yrs. mos. ds.

(Signed) R. E. Sloan M. D.

June 23 1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: June 27 1916

20. UNDERTAKER: Schreiber & Hickman — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14631
Registered No. 153

Registration District No. 2
Primary Registration District No. 1004

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 815 Jefferson St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Story Benjamin Sargent

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec 28 1902 (Month) (Day) (Year)

7. AGE 13 Yrs. 5 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Student
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF FATHER C A Sargent.

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Mary E. Lewis.

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C A Sargent
(Address) Boise Idaho

15. Filed 6/20 1916 E J Lofton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 19 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ June 19 1916, ~~to~~ 1916, that I ~~last~~ saw him ~~alive~~ dead on June 19 1916 and that death occured on the date stated above, at 6.15 P.M.

The CAUSE OF DEATH* was as follows:
Accidently Electrocuted
In alley at Rear of 815
(Duration) ~~Yrs.~~ ~~mos.~~ ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) Clyde E Summers Coroner
6/21 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: June 21 1916

20. UNDERTAKER: Clyde Summers Co. — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14632

Registered No. 152

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 1121 W. Jefferson St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ellen F. Gilmore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Feb (Month) 3rd (Day) 1838 (Year)

7. AGE: 77 Yrs. 7 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Chatham, N.Y.

10. NAME OF FATHER: H. S. Tharpe

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Emaline Lacey

13. BIRTHPLACE OF MOTHER (State or Country): Conn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. F. Valentine

(Address) Boise

15. Filed 6/17 191 6

Local Registrar Springer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1916, to June 16 1916, that I last saw her alive on June 15 1916, and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Myocarditis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Springer M. D.

June 17 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/18 1916

20. UNDERTAKER: Schreiber & Siedenfaden — ADDRESS: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14633

Registered No. 150

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna H. Fogarty

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. July (Month) 24 (Day) 1847 (Year)

7. AGE: 68 Yrs. 10 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Mr Geady

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph A. Fogarty

(Address) Big Canon Wyo.

15. Filed 6/16 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 13th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3rd 1916, to June 13th 1916, that I last saw h[illegible] alive on the 13th June 1916, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Cancer right breast

Had trouble 5 years

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) J C Davis M. D.

19..... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 6/17 1916

20. UNDERTAKER: Schreiber & Hedenkamp — ADDRESS: Boise

SYMS - YORK CO., PTRS. & BORS. 24854

Davis

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 14634
Registered No. 147

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 410 Ash St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julia Emma Tregaskis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. Jan. 20th (Month) (Day) 1860 (Year)

7. AGE: 56 Yrs. 4 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Stephen Henderson

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Kathrine Mace

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Vernon H. Tregaskis
(Address) 1308 W. Bannock Boise

15. Filed 6/17 1916 Ex Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/9 1916, to 6/13 1916, that I last saw h er alive on 6/13 1916, and that death occured on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Hypostatic Intoxication

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Epilepsia Right Lobe Pneumonia

(Duration) ... yrs. ... mos. ... ds.

(Signed) Fred A. Adams M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. | DATE OF BURIAL: 6/14 1916

20. UNDERTAKER: Schrieber & Simpson | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County Ada

City or Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 110 East Bannock St.)

File No. 14635 141

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Prow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 15 (Day) 1842 (Year)

7. AGE: 73 Yrs. 11 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: Phillip Prow

11. BIRTHPLACE OF FATHER (State or Country): Am.

12. MAIDEN NAME OF MOTHER: Mary Hailey

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Isaac Prow
(Address) Meridian

15. Filed 6/12 1916 E J Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13 1916, to June 9 1916, that I last saw h— alive on June 9 1916, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) P E Shuntz M. D.

June 9 1916 (Address) Boise Ada

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Idaho — DATE OF BURIAL: June 12 1916

20. UNDERTAKER: Schreiber & Hindman — ADDRESS: Boise

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 14636
Registered No. 140

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orva Wisner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Sep (Month) 4 (Day) 1904 (Year)
7. AGE: 11 Yrs. 9 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer)...
9. BIRTHPLACE (State or Country) Washington.
10. NAME OF FATHER W. O. Wisner
11. BIRTHPLACE OF FATHER (State or Country) Michigan
12. MAIDEN NAME OF MOTHER Susie L Kline.
13. BIRTHPLACE OF MOTHER (State or Country) Nebraska
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dr W. O. Wisner
(Address) Spokane Wash.
15. Filed 6/12 1916 E. L. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 12 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 15 1916, to June 12 1916, that I last saw h.. alive on June 11 1916, and that death occured on the date stated above, at 6:12 A.M.
The CAUSE OF DEATH* was as follows:
Typhoid fever
(Duration) Yrs. 1 mos. 14 ds.
Contributory (Secondary) streptococcus infection
(Duration) yrs. mos. 21 ds.
(Signed) M. Hallenan M. D.
6/14 1916 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: June 14 1916
20. UNDERTAKER: Frye Summers Co. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14657

Registered No. 137

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 907 7th Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James E. Allan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Oct (Day) 16 1866 (Year)

7. AGE: 49 Yrs. 7 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Post Master

(b) General nature of industry, business, or establishment in which employed (or employer)... at Unity, Sask.

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER William Allan

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Charity Birdsell

13. BIRTHPLACE OF MOTHER (State or Country) Ontario Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Merricar

(Address) Eagle Idaho

15. Filed 6/8 1916

E. J. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) June (Day) 7th 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1916, to June 7 1916, that I last saw him alive on June 7 1916, and that death occured on the date stated above, at 9.30 P.M.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Nephritis Chronic

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. Soprenger M. D.

June 8 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Waterford Ontario Canada | DATE OF BURIAL: June 13 1916

20. UNDERTAKER: Fry & Summers | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14638

Registered No. 136

Registration District No. 2

Primary Registration District No. 1004

(No. 812 O Farrell St.)

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Greta Bills

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 30th (Day) 1902 (Year)

7. AGE: 13 Yrs. 9 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Victor Colo

10. NAME OF FATHER: Wm Bills

11. BIRTHPLACE OF FATHER (State or Country): Ills.

12. MAIDEN NAME OF MOTHER: Hilma Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Bills

(Address) Boise

15. Filed 6/7 1916

E. J. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29 1916, to June 5 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. Calvert M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/8 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14639

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 State St.)

Registration District No .....

Primary Registration District No 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katherina C Peters

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 15 (Day) 1871 (Year)

7. AGE: 44 Yrs. 6 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Hans Offe

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Elisabetha Peters

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara F. Peters

(Address) Boise

15. Filed June 6 1916 E. J. Caton Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 5th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/21 1916, to 6/5 1916, that I last saw her alive on 6/4 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(Duration) ..... Yrs. 9 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred A. Willcuts M. D.

6/3 1916 (Address) Falk Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/7 1916

20. UNDERTAKER: Schreiber & Hildenbrand — ADDRESS: Boise

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 1004

Primary Registration District No.

(No. 1006 6 mo 10 St. St.)

File No. 14640

Registered No. 134

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William A. Simpson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
male.	White.	Married (the word.)

6. DATE OF BIRTH

March 3 1846
(Month) (Day) (Year)

7. AGE

70 yrs. 3 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work Stockman

(b) General nature of industry business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) New York.

10. NAME OF FATHER John Simpson

11. BIRTHPLACE OF FATHER (State or Country) New York.

12. MAIDEN NAME OF MOTHER Mary Walrod.

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dora C. Simpson

(Address)

15. Filed June 5 1916 E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 4th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1915, to Apr. 15 1916, that I last saw h[illegible] alive on Apr 16th 1916, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(Duration) 1 yrs. 6 mos. ds.

Contributory (Secondary) Unknown

(Duration) yrs. mos. ds.

(Signed) J. M. Taylor M. D.

June 5 1916 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill. DATE OF BURIAL June 5 1916

20. UNDERTAKER Fry & Summers. ADDRESS Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14641

Registered No. 132

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 713 N 13 St. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Carman Pence

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. May 28 1844
(Month) (Day) (Year)

7. AGE: 72 Yrs. 0 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.., Retired Capalist
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER William Pence

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Mary Thurston

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank D Makswell

(Address) 713 N 13 St Boise Ida

15. Filed June 3 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 30 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ Boise
May 30 1916, ~~to~~ ....., 191..,
that I last saw h~~e~~ ~~alive~~ on dead May 30 1916,
and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

While in Post office at Boise Ida

he died

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E Summers Coroner M. D.

6/3 1916 (Address) Boise / Ida Ada County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: June 4 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

5V166 - YORK CO., PTRS. & BOKS.

FORM V. S. No. 5-25 M. 1-16-13

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14642

Registered No. 148

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 1019 Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cecilio Bideganeto

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ~~Feb~~ Jan 5 1916 (Month) (Day) (Year)

7. AGE: ——Yrs. 5 Mos. 9 ds. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Boise, Idaho

10. NAME OF FATHER Roman Bideganeto

11. BIRTHPLACE OF FATHER (State or Country) Spain

12. MAIDEN NAME OF MOTHER Maria Stasllaria

13. BIRTHPLACE OF MOTHER (State or Country) Spain,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address) Anastasio Jayo

15. Filed 6/13 1916

E. L. Paxton
Local Registrar

Pittinger

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 14th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1916, to 6/14 1916, that I last saw him alive on 6/14 1916, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

(a) Pulmonary Tuberculosis

(Duration) Yrs. mos. ds.

Contributory (Secondary) Whooping Cough

(Duration) 2 yrs. mos. ds.

(Signed) Fred A Pettingill M. D.

6/14 1916 (Address) Falk Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Boise, Idaho,

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 6/15 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 14643
Registered No. 37

1. PLACE OF DEATH.
County of Ada
City of ....
(No. south east of Meridian St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Pilgrim

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 26 (Day) 1916 (Year)

7. AGE: ....Yrs. 7 Mos. 5 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9. BIRTHPLACE (State or Country): Ada Co.

10. NAME OF FATHER: L. G. Pilgrim

11. BIRTHPLACE OF FATHER (State or Country): Ore.

12. MAIDEN NAME OF MOTHER: Mamie Crawford

13. BIRTHPLACE OF MOTHER (State or Country): Ada Co.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. F. Crawford
(Address) Meridian

15. Filed June 1 1916
E. J. Eaton Local Registrar

SYMS-YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1916, to June 1 1916, that I last saw h in alive on May 31 1916, and that death occured on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:
Mal development
(Duration) ....Yrs. mos. 5 ds.
Contributory (Secondary)
(Duration ....yrs. ....mos. ....ds.
(Signed) C. L. Dutton M. D.
19.... (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: June 1 1916

20. UNDERTAKER: Schreiber & Hidenfeldt — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 14644
Registered No. 155

1. PLACE OF DEATH.
County of Ada.
City of Boise.
(No. St. Lukes Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Catherine Smith.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W.	Single

6. DATE OF BIRTH. June 25 1916.
(Month) (Day) (Year)

7. AGE ..... Yrs. — Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none.
(b) General nature of industry, business, or establishment in which employed (or employer)... —

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Ralph Smith.

11. BIRTHPLACE OF FATHER (State or Country) Nebraska.

12. MAIDEN NAME OF MOTHER Catherine Macher.

13. BIRTHPLACE OF MOTHER (State or Country) Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ralph T. Smith
(Address) Boise, Idaho

15. Filed 6/27 1916
E. A. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 27 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1916, to June 27 1916, that I last saw h.r. alive on June 26 1916, and that death occured on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:

Open Foramen Ovale,

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. Blodgett M. D.

6/27 1916. (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	June 27 1916
20. UNDERTAKER	ADDRESS
Gray & Demmers	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 14645

Registered No. 151

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise,

(No.) 1502 Ellis St.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give NAME instead of street and number.

2. FULL NAME Walter Stone McCloud

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June 17 (Month) (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Ida

10. NAME OF FATHER: Walter S McCloud

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Mabel Stone

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Olive E Jones

(Address) Boise Ida

15. Filed 6/16 1916 E J Eaton Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 17 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Evening June 16 1916, to 2 A.M. morning 1916, that I last saw h..... alive on ..... 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Prolonged Labor & failure of expulsion from vagit. Contr. As result of large fetus

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Edw. C. Kelly M.D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: June 17 1916

20. UNDERTAKER: Frye & Summers

ADDRESS: Boise Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9

Primary Registration District No.

File No. 14646

Registered No.

1. PLACE OF DEATH.

County of Ada

City of near Eagle

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hiram G. Saxton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. April (Month) 20 (Day) 1834 (Year)

7. AGE: 82 Yrs. 2 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Joseph Saxton

11. BIRTHPLACE OF FATHER (State or Country): Not obtainable

12. MAIDEN NAME OF MOTHER: Margrite Glispy

13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. L. Saxton

(Address) Boise R. D. 1.

15. Filed July 5 1916

L. B. Harris
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 2nd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1916, to July 2nd 1916, that I last saw h. i/m. alive on July 2nd 1916, and that death occured on the date stated above, at 8 10 P.M.

The CAUSE OF DEATH* was as follows:

Clonic convulsions at frequent intervals for 30 hours

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) had had several mild apoplectic strokes

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Taylor M. D.

July 3 1916 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery — DATE OF BURIAL: July 5 1916

20. UNDERTAKER: Grey & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5 25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14647
Registered No. 29

1. PLACE OF DEATH.
County of Bannock Idaho
City of Offard
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2046
(No. ....., ... St.)

2. FULL NAME Mar Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 14 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bannock Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Mable Lewis

13. BIRTHPLACE OF MOTHER (State or Country) Richmand Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Francis Lewis
(Address) Offord Idaho

15. Filed June 16 1916. Essie Kerley Local Registrar

SVMB – YORK CO., PTRS. & BOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1916, to June 19 1916, that I last saw h. im alive on June 19 1916, and that death occured on the date stated above, at 4. P. M.

The CAUSE OF DEATH* was as follows:

Premature birth
Lived 3 hours

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) ✓

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G W Slate M. D.
June 20 1916. (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Offord Idaho — DATE OF BURIAL: June 20 1916

20. UNDERTAKER: none — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

* MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14648

Registered No. 8-30

1. PLACE OF DEATH.

County of Benewah

City of Sede Springs Id

(No. ....., ... St.)

Registration District No. 11

Primary Registration District No. 2047

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Howe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.)

6. DATE OF BIRTH.

Unknown Unknown 1890
(Month) (Day) (Year)

7. AGE

26 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Stockmen

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE

(State or Country) Ohio

10. NAME OF FATHER Albert Howe

11. BIRTHPLACE OF FATHER

(State or Country) Ohio

12. MAIDEN NAME OF MOTHER Lucy Smith

13. BIRTHPLACE OF MOTHER

(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eric Kaarby

(Address) Sede Springs Ida

15.

Filed June 16, 1916 Eric Kaarby
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 16 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1916, to June 16 1916, that I last saw h.. alive on June 16 1916, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Gunshot wound of abdomen

2 Hrs.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) None

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Eric Kaarby M. D.

June 16 1916. (Address) Sede Springs, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Genesee Idaho | DATE OF BURIAL: June 17 1916

20. UNDERTAKER: C. C. Schenkel | ADDRESS: Genesee

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 81

Primary Registration District No. 215-8

File No. 14649

County of Bonner

City of Priest River (No. ..... St.)

Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Bombino

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 7 (Day) 1881 (Year)

7. AGE: 34 Yrs. 6 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Peter Bombino

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Rosalea Mascarello

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Angel Mascarello
(Address) Priest River

15. Filed June 7 1916 E. D. McCarty Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1916 to June 7 1916, that I last saw h[illegible] alive on June 6 1916, and that death occured on the date stated above, at 9 3/4 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(Duration) Yrs. 18 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. D. McCarty M. D.

6/7 1916 (Address) Priest River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Priest River — DATE OF BURIAL: June 8 1916

20. UNDERTAKER: J. E. Frist — ADDRESS: Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 81

Primary Registration District No. 2158

File No. 14650

County of Kootenai

City of Post Falls (No. ..... St.)

Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Per Justus Falk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) ? (Day) 1860 (Year)

7. AGE: 55 Yrs. 8 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweeden

10. NAME OF FATHER: Swan Falk

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Elizabeth Jacobson

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F. Falk

(Address) Pinehurst Idaho

15. Filed June 22 1916 — C D McCarty, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 6.30a M.

The CAUSE OF DEATH* was as follows:

Ruptured aortic (Saccular) aneurism.

(Duration) ? Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C D McCarty M. D.

June 21 1916 (Address) Post Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Post Falls Post Falls — DATE OF BURIAL: June 23 1916

20. UNDERTAKER: J E Frost — ADDRESS: Post Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-35 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14651

Registered No. .....

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

County of Bonner

City of Priest River (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Langtry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): unknown

6. DATE OF BIRTH. 1846 (Month) (Day) 1 (Year)

7. AGE: 70 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Lumberyard.

9. BIRTHPLACE (State or Country): —

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. W. Lowery

(Address) Priest River

15. Filed June 1916 C. D. McCarty Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Cancer stomach
accidental. stuck by
falling tree

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Knapp Cor M. D.

6/5 1916 (Address) Hayden Lake

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Priest River — DATE OF BURIAL: June 8 1916

20. UNDERTAKER: G. H. Gray — ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYRS - YORK CO., PTRS. & SONS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5
Primary Registration District No. 2009
File No. 14652
Registered No. 1

1. PLACE OF DEATH.
County of Canyon
City of New Plymouth (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Esther Florance Howe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fmle
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 13 (Day) 1897 (Year)

7. AGE: 18 Yrs. 9 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Edward Howe

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Ella Eriksen

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Helene M. Howe
(Address) New Plymouth

15.
Filed 7-11-1916
Wm J. Arendale
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1916, to Apr 3 1916, that I last saw her alive on ... 2 1916, and that death occured on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Sarcoma of the lung.

(Duration) Yrs. 15 mos. ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm J. Arendale M. D.
7-11 1916 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: New Plymouth — DATE OF BURIAL: April 5 1916

20. UNDERTAKER: A. Meyer — ADDRESS: New Plymouth

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1065
File No. 14653
Registered No. ____

1. PLACE OF DEATH.
County of Twin Falls
City of ____ (No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada Elizabeth Flynn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. 8th (Month) (Day) 1868 (Year)

7. AGE 47 Yrs. 7 Mos. 9 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: A. J. Withers

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Elizabeth West

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) T. J. Flynn
(Address) Twin Falls RFD #1

15. Filed June 26 1916 John J. Coughlan Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 21 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1916, to June 20 1916, that I last saw her alive on June 19 1916; and that death occured on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of heart

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) T. Howelson M. D.
June 23 1916. (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR ~~REMOVAL~~: Twin Falls — DATE OF BURIAL: 6-26-1916

20. UNDERTAKER: C. J. Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 14654
Registered No. 15

1. PLACE OF DEATH.
County of Lemhi
City of May
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert Ervin Grubb

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
January 3rd 1913
(Month) (Day) (Year)

7. AGE
3 Yrs. 5 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) May Idaho

10. NAME OF FATHER: Dell Grubb

11. BIRTHPLACE OF FATHER
(State or Country) Illinois

12. MAIDEN NAME OF MOTHER: Isabella Pearl Adams

13. BIRTHPLACE OF MOTHER
(State or Country) Challis Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dell Grubb
(Address) May Idaho.

15.
Filed June 18 1916
E O Henderson
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June 17th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 9-30 A M.

The CAUSE OF DEATH* was as follows:
Accidently
Shot by his five year old brother
With 30-30 winchester R/R

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) William C Hobbs Coroner M. D.
6-17th 1916 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: May Idaho
DATE OF BURIAL: 6-18th 1916

20. UNDERTAKER: W. C. Hobbs Salmon
ADDRESS: Idaho.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 14655
Registered No. 16

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maurice Blanchard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): divorced

6. DATE OF BIRTH. June 22 1864 (Month) (Day) (Year)

7. AGE: 53 Yrs. 0 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: inventor and farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: do not know

11. BIRTHPLACE OF FATHER (State or Country): " " "

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Le Roy Blanchard
(Address) Salmon, Idaho

15. Filed June 30 1916 E. D. Herndon Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 29th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1916, to June 29th 1916, that I last saw h.. alive on June 14th 1916, and that death occured on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:

Diabetes

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration 4 yrs. 3 mos. ..... ds.

(Signed) F. S. Wyatt M. D.

Jun 7 1916 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery
DATE OF BURIAL: July 1st 1916

20. UNDERTAKER: W. C. Noble
ADDRESS: Salmon Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 14656
Registered No. 17

1. PLACE OF DEATH.
County of Lemhi
City of Myers Cove
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bert A Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Do not know (Month) (Day) (Year)
7. AGE: about 44 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): California
10. NAME OF FATHER: Do not know
11. BIRTHPLACE OF FATHER (State or Country): " " "
12. MAIDEN NAME OF MOTHER: " " "
13. BIRTHPLACE OF MOTHER (State or Country): " " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W.C. Hoebler
(Address) Salmon Idaho.
15. Filed July 5 1916 Ed Sherwood Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 4th 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Suicidal
with self intent that in Lead
with 32-40 Rifle.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W.C. Hoebler Coroner
7-6 1916 (Address) Salmon Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Myers Cove Idaho. DATE OF BURIAL: 7-6 1916
20. UNDERTAKER: W.C. Hoebler ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNR. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14657

Registered No. 18

1. PLACE OF DEATH.

County of Lemhi

City of Salmon

(No. ..... St.)

Registration District No. 41

Primary Registration District No. 2116

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nellie DeLong

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. February 18th 1870 (Month) (Day) (Year)

7. AGE: 46 Yrs. 4 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Lynn Derkhoff

11. BIRTHPLACE OF FATHER (State or Country): Holland

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles DeLong

(Address) Henday Idaho.

15. Filed June 26 1916 E. J. Henders Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 26th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1915, to June 26 1916, that I last saw h[illegible] alive on June 25 1916, and that death occured on the date stated above, at 7A M.

The CAUSE OF DEATH* was as follows:

Pyo nephrosis

Acute (Duration) one year mos. ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Hammer M. D.

6/27 1916 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 6-27 1916

20. UNDERTAKER: W. C. Doeble — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lemhi

City of Salmon

Registration District No. 41

Primary Registration District No. 2116

(No. ..... St.)

File No. 1658

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Taylor Stiles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April 21st 1915 (Month) (Day) (Year)

7. AGE: 1 Yrs. 3 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Gibbonsville

10. NAME OF FATHER Leon Stiles

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Nellie Jones

13. BIRTHPLACE OF MOTHER (State or Country) Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leon Stiles

(Address) Salmon Idaho

15. Filed July 9 1916 Ed Vaughn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 8th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1916, to July 8 1916, that I last saw h[illegible] alive on July 8 1916 and that death occured on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Measles (Duration ..... yrs. ..... mos. 3 wks. ds.

(Signed) Chas F. Hammer M. D.

July 10 1916 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 7-9" 1916

20. UNDERTAKER: W.C. Noble — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 116
File No. 14659
Registered No. 26

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Ophallenia Grovell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May 24th (Month) (Day) 1877 (Year)

7. AGE: 39 Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Mr Kohl

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fred Grovell
(Address) Salmon Idaho

15. Filed July 10 1916 E. D. Hendon Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 9th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1916, to July 5 1916, that I last saw h.. alive on July 5 1916, and that death occured on the date stated above, at 6 21 A.M.

The CAUSE OF DEATH* was as follows:

Aorta regurgitation
Chronic Nephritis (Duration) two Yrs. mos. ds.
Contributory (Secondary)
Cirrhosis of Liver (Duration) 3 yrs. mos. ds.
(Signed) Chas F Hannon M. D.
7/10 1916 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 7-10th 1916

20. UNDERTAKER: W. C. Noeble — ADDRESS: Salmon Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 14662
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Troy
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Blanche Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH. April 3 1916
(Month) (Day) (Year)

7. AGE — Yrs. — Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Troy Ida

10. NAME OF FATHER John C. Harris

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Minnie Bottorff

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John C. Harris
(Address) Troy Ida

15. Filed April 17 1916 J. M. McCall Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3 1916, to Apr 12 1916, that I last saw her alive on April 4 1916, and that death occured on the date stated above, at 3.00 P.M.
The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) — Yrs. — mos. 4 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. McCall M. D.
Apr. 13 1916 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Troy Ida.	Apr. 14 1916
20. UNDERTAKER	**ADDRESS**
John C Harris	Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 14663
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Troy
(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Clifford Pearson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan. (Month) 13 (Day) 1896 (Year)

7. AGE: 30 Yrs. 5 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Genesee Idaho.

10. NAME OF FATHER: Nils Pearson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Johanna Ruberg.

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Carl T Anderson
(Address) Troy Idaho

15. Filed June 15 1916 — John McColl, Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1914, to June 14 1916, that I last saw h. alive on June 14 1916, and that death occured on the date stated above, at 8.30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Interculosis

(Duration) 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) John McColl M. D.

June 15 1916 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wresdalia Cemetary - Troy Idaho — DATE OF BURIAL: June 16 1916

20. UNDERTAKER: J. E. Pickard — ADDRESS: Troy Ida.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14664

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Latah

City of Troy

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

2. FULL NAME John E Payne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	married

6. DATE OF BIRTH: July — 1856 (Month) (Day) (Year)

7. AGE: 59 yrs. 6 mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Shopkeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Steven Payne

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Alice Payne
(Address) Troy, Ida

15. Filed March 14 1916 J. McCall Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar 14 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1916, to Mar 14 1916, that I last saw h alive on Mar 13 1916, and that death occurred on the date stated above, at 10 p. M.

The CAUSE OF DEATH* was as follows:
Chronic nephritis

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) Mob. most time —

(Duration) yrs. mos. ds.

(Signed) E H Field M. D.

Mar 14 1916 (Address) E H Field

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 20 yrs. — mos. — days. In the State. — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burnt Ridge — DATE OF BURIAL: March 16 1916

20. UNDERTAKER: J. L. Pickerd — ADDRESS: Troy Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 14665
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Troy
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Kelly
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unknown (Month) (Day) 1846 (Year)

7. AGE: 70 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Isle of Man

10. NAME OF FATHER: James Kelly

11. BIRTHPLACE OF FATHER (State or Country): Isle of Man

12. MAIDEN NAME OF MOTHER: Mary Corkill

13. BIRTHPLACE OF MOTHER (State or Country): Isle of Man

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jas. Kelly
(Address) Troy Ida

15. Filed June 21 1916
J. M. McCall
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 1916, to June 21 1916, that I last saw him alive on June 16 1916, and that death occured on the date stated above, at 1.00 P. M.
The CAUSE OF DEATH* was as follows:

Chronic endocarditis and myocarditis

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. McCall M. D.
June 21 1916 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burnt Ridge Cemetery — DATE OF BURIAL: June 23 1916

20. UNDERTAKER: W. J. Kelly — ADDRESS: Troy Idaho

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14666

Registered No. .....

1. PLACE OF DEATH.

County of Latah.

City of Troy.

(No. ....., ... St.)

Registration District No. 64

Primary Registration District No. 2144

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Z. Kelham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.

6. DATE OF BIRTH. Nov. (Month) 5 (Day) 1868 (Year)

7. AGE: 47 Yrs. 5 Mos. 17 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House-Wife

(b) General nature of industry, business, or establishment in which employed (or employer): /

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Austin Snead.

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Jane Haynes

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Kelham

(Address) Troy Ida.

15. Filed Apr. 22 1916 J. M. McCall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct- 20 1914, to April 21 1916, that I last saw h. alive on April 21 1916, and that death occured on the date stated above, at 7.45 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4 Yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. McCall M. D.

Apr 22 1916 (Address) Troy Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hog Creek Cemetary, Troy

DATE OF BURIAL: Apr 24 1916

20. UNDERTAKER: Chas. Kelham

ADDRESS: Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Troy

Registration District No. 64

Primary Registration District No. 2144

(No. ....., ... St.)

File No. 14667

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Edison Linsmore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH. May (Month) 14 (Day) 1916 (Year)

7. AGE 61 Yrs. 2 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Lewis Co. Mo.

10. NAME OF FATHER Samuel Linsmore

11. BIRTHPLACE OF FATHER (State or Country) Tenesee

12. MAIDEN NAME OF MOTHER Martha Blakley

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lydia Linsmore

(Address) Troy Idaho.

15. Filed May 15 1916 J. M. McColl Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 1916, to May 14 1916, that I last saw him alive on May 14 1916, and that death occured on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor

(Duration) — Yrs. 2 mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. McColl M. D.

May 15 1916 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Avon Idaho	May 17 1916

20. UNDERTAKER	ADDRESS
J. A. Prickard	Troy Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRON - WEBB CO., PTRS. & BKBS. 23658

FORM U. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
(No. ..... St.)

File No. 14668
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Peter Beckman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR, DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH. May (Month) 31 (Day) 1837 (Year)

7. AGE: 88 Yrs. 8 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: — Frost

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: (Unknown)

13. BIRTHPLACE OF MOTHER (State or Country): Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ferdinand Beckman
(Address) Troy Idaho.

15. Filed Feb. 14 1916 — J. M. McCall, Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 7 1916, to Feb. 12 1916, that I last saw h. alive on Feb. 11 1916, and that death occured on the date stated above, at 12 noon M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) — Yrs. — mos. 8 ds.

Contributory (Secondary): Fractured Hip

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. McCall M. D.

Feb. 14 1916 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burnt Ridge Cemetary — DATE OF BURIAL: Feb. 14 1916

20. UNDERTAKER: J. R. Pickard — ADDRESS: Troy Idaho

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Ida[illegible]
BOARD OF HE[illegible]
Bureau of Vital St[illegible]
File No. 1460[illegible]
Registered No.

1. PLACE OF DEATH.
County of Custer
City of Challis
Registration District No.
Primary Registration District No.
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joe Anderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE: 71 yrs. mos. ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockgrower
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wyoming

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Michael
(Address) Challis, Idaho

15. Filed June 10th 1916 K. D. Williams
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 8 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 13 1916, to June 8 1916
that I last saw him alive on June 8 1916
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Tumor of liver
Brights disease

(Duration) yrs. 6 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. W. Kelley M. D.
June 9 1916. (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Challis
DATE OF BURIAL: June 10th 1916

20. UNDERTAKER: K. D. Williams
ADDRESS: Challis Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14670
Registered No.

1. PLACE OF DEATH.
County of Lewis
City of Kamiah
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1
Primary Registration District No. 178
(No. ..., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Cicero Hogan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 28th (Day) 1847 (Year)

7. AGE: 67 yrs. — mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee.

10. NAME OF FATHER: Not known.

11. BIRTHPLACE OF FATHER (State or Country): Not known.

12. MAIDEN NAME OF MOTHER: Not known.

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. E. Hagerman
(Address) Kamiah Idaho

15. Filed July 11th 1916 H. W. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10th 1916, to July 10th 1916, that I last saw him alive on July 7th 1916, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Cancer of the mouth
(Duration) ? yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. W. McMahan M. D.
7/11 1916 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery Kamiah Ida. | DATE OF BURIAL: July 11th 1916

20. UNDERTAKER: C. J. Johnson | ADDRESS: Kamiah Ida

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

Primary Registration District No. 2184

File No. 14674

Registered No. 41

County of Idaho

City of Kooskia (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice May Engle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: May (Month) 18 (Day) 1916 (Year)

7. AGE: ..... yrs. 1 mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kooskia – Idaho

10. NAME OF FATHER Lee Engle

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Matilda Overton

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lee Engle
(Address) Kooskia Idaho

15.
Filed ..... 191... J. M. Verbeck Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1916, to June 19 1916, that I last saw her alive on June 19 1916, and that death occurred on the date stated above, at 12:00 P.M.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Verbeck M. D.

June 19 1916 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kooskia Cemetery	June 20 1916
20. UNDERTAKER	ADDRESS
Family	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

County of Idaho

Primary Registration District No. 2184

File No. 14676

City of Talon (No. ....., ... St.)

Registered No. 113

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Watson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male		Single

6. DATE OF BIRTH: June (Month) 25 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John Watson

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Ida Patterson

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse Watson

(Address) Talon Idaho

15.

Filed June 26 1916 J.M. Verbeckmoes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Talon Cemetery	June 26 1916
20. UNDERTAKER	ADDRESS
Family	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 6 14677
Registered No. 41

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ingward A. Olsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 19 (Day) 1916 (Year)

7. AGE: ....Yrs. 11 Mos. ....ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Oliver Olsen

11. BIRTHPLACE OF FATHER (State or Country): Chicago Ill.

12. MAIDEN NAME OF MOTHER: Laura Newcomb

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Oliver Ingward Olsen
(Address) .....

15. Filed 6-30 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1916, to at Birth 191..., that I last saw h/im alive on June 29 1916, and that death occured on the date stated above, at —M.

The CAUSE OF ~~DEATH*~~ was as follows:
Marasmus

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Prematurity Birth
(Duration — yrs. — mos. — ds.
(Signed) C E Montague M. D.
6/30 1916 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs. .....mos. 10 days. In the State —yrs. —mos. —days
Where was disease contracted if not at place of death? —
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: June 30 1916
20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai
City of Coeur D' Alene

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

File No. 14678
Registered No. 472

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gladys Mary Waldon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 12 (Day) 1899 (Year)

7. AGE: 17 Yrs. 4 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... at home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: H. W. Waldon

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Friel

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ben Wood X
(Address) 1053 N. A. St. Coeur D'Alene

15. Filed July-8 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6" (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 31 1916, to May 28 1916, that I last saw h[illegible] alive on May 28 1916 and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Hoadley M. D.
7/7 1916 (Address) Coeur d Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. Thomas Cemetary — DATE OF BURIAL: July 8 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14679

Registered No. 1240

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No 29

Primary Registration District No 1050

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James L. Garner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. December 25th 1848 (Month) (Day) (Year)

7. AGE: 67 Yrs. 5 Mos. 23 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. L. Triplett

(Address) Leslie, Idaho

15. Filed 6-18 1916

J. Hayes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10th 1916, to June 17th 1916, that I last saw him alive on June 17 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

.....(Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary) None

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Montague M. D.

6/18 1916 (Address) 6th. Sherman ave

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: June 18 1916

20. UNDERTAKER: T. C. Hudson — ADDRESS: C. d'A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D'Alene

Registration District No. 29

Primary Registration District No. 1050

(No. ....., ... St.)

File No. 6

Registered No. B4680

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orville Homer Hammond

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Apr. (Month) 12 (Day) 1841 (Year)

7. AGE: 75 Yrs. 2 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Hannaw Hammond

11. BIRTHPLACE OF FATHER (State or Country): ~~Penn.~~ N.Y.

12. MAIDEN NAME OF MOTHER: Emily Shumway

13. BIRTHPLACE OF MOTHER (State or Country): Vermont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harvard H. Hammond
(Address) Coeur d'Alene Ida

15. Filed 7-3 1916 — Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3rd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2nd 1916, to July 3rd 1916, that I last saw him alive on July 3rd 1:30 p.m. 1916, and that death occured on the date stated above, at 3:10 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) — Yrs. — mos. 4 ds.

Contributory (Secondary) Old age, together with cold

(Duration ..... yrs. ..... mos. 2 ds.

(Signed) Alexander Cairns M. D.

7/3/ 1916 (Address) Alexander Cairns

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: July 5 1916

20. UNDERTAKER: Cassidy & Nelson — ADDRESS: Coeur D'Alene

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 614681

Registered No. 38

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No. 29

Primary Registration District No. 105

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha F. Vonburg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. About 60 years. 1 (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Chicago Illinois

10. NAME OF FATHER Fredrik Vonburg

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Anna Munsen

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Wilkes

(Address) Coeur d'Alene

15. Filed 6-22-1916 D. Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 22. 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from —— 191..., to —— 191..., that I last saw h— alive on —— 191..., and that death occured on the date stated above, at —— M.

The CAUSE OF DEATH* was as follows:

Heart disease

Old age

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) asthma

(Duration 30. yrs. ..... mos. ..... ds.

(Signed) Alexander Cairns Coroner. M. D.

7-3-1916 (Address) 611 Garden Ave C d'A. Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lot Boy — DATE OF BURIAL: June 24 1916

20. UNDERTAKER: F. E. Kodat — ADDRESS: C. d. A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai — Registration District No. 29

City of Coeur D'Alene — Primary Registration District No. 1050

(No. ..... , ... St.)

File No. 14683

Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Axel N. Sundin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Apr. (Month) 2 (Day) 1877 (Year)

7. AGE 39 Yrs. 2 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Scaler

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Sundin

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Nardin

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Axel Sundin

(Address) .....

15. Filed June 16 1916 — J. Hughes, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1916, to June 14 1916, that I last saw h. m. alive on June 14 1916 and that death occured on the date stated above, at 4 am M.

The CAUSE OF DEATH* was as follows:

Fracture of Spine

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Wagner M. D.

6/15 1916 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: June 16 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & STNRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 6 14684
Registered No. 13

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Weeks.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
6. DATE OF BIRTH. May (Month) 2 (Day) 1835 (Year)
7. AGE: Yrs. 81 Mos. 2 ds. 8
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Canada
10. NAME OF FATHER J. Tracy Welch
11. BIRTHPLACE OF FATHER (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Mary Lamport
13. BIRTHPLACE OF MOTHER (State or Country) England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H H Mitchell
(Address) 312 Military Drive
15. Filed June 10 1916 J. Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) July (Day) 10 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 29 1916, to July 10 1916, that I last saw h[illegible] alive on July 9 1916, and that death occured on the date stated above, at 4:10 A M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) — Yrs. — mos. 12 ds.
Contributory (Secondary) Arterio sclerosis
(Duration) — Yrs. — mos. — ds.
(Signed) J. C. Myers M. D.
7/10 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL: July 11 1916
20. UNDERTAKER: J. Hazen. — ADDRESS: Spokane

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING.

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14686

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 79

Primary Registration District No. 2156.

County of Bonneville

City of Bonneville (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information. Lenita.

2. FULL NAME James L Duncan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 60 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer Mare

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Aberdeen Scotland

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) — —

12. MAIDEN NAME OF MOTHER — —

13. BIRTHPLACE OF MOTHER (State or Country) — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed May 17th 1916. E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 15th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

(Dropsy Heart)

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonneville County Idaho

DATE OF BURIAL: 5/18 1916

20. UNDERTAKER: John T Moore

ADDRESS: Bonneville County Idaho

BYRNE - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 3156.
File No. 14688
Registered No. .....

1. PLACE OF DEATH
County of Bonneville
City of Bonneville Ferry (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nellie Mary Meyers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. January (Month) 12 (Day) 1903 (Year)

7. AGE: 12 Yrs. 6 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Woodbury Co Iowa

10. NAME OF FATHER: John T. Meyers

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Mary E Parson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. T. Meyers
(Address) Bonneville Ferry Ida

15.
Filed June 18 - 1916.
E. B. Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 17th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h...alive on ..... 191...,
and that death occured on the date stated above, at 4.30 P. M.
The CAUSE OF DEATH* was as follows:

Drowning
(accidental)

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs.....mos.....ds.

(Signed) E. B. Fry M. D.
6/17/1916 (Address) Bonneville Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonneville Ferry Ida
DATE OF BURIAL: 6/19 1916

20. UNDERTAKER: John T. Moore
ADDRESS: Bonneville Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14691

Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of St. Charles
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Fredrick Jerrald Hill

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Sept. (Month) 17 (Day) 1915 (Year)

7. AGE
1 yrs. 9 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Child
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Salt Lake

10. NAME OF FATHER Frank D Hill.

11. BIRTHPLACE OF FATHER (State or Country) Salt Lake City

12. MAIDEN NAME OF MOTHER Ammy Evaline Brandley

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed July 12 1916 John Mattson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw h— alive on — 191..., and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:
Drowned

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. Sutton M. D.
19.... (Address) Paris Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Charles Ida	6/26 1916
20. UNDERTAKER	ADDRESS
Miss Bagley	Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14692

1. PLACE OF DEATH
County of Bear Lake
City of St Charles
Registration District No. 55
Primary Registration District No.
(No. St.)
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Wilkes.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): married

6. DATE OF BIRTH: April (Month) 5 (Day) 1849 (Year)

7. AGE: 67 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Charles

10. NAME OF FATHER: Wm. Wilkes

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Bena Hemmert

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed July 12 1916 John Mattson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1916 to July 7 1916, that I last saw h alive on 1916, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
Failure to Compensate
(Duration) 1 yrs. 1 mos. ds.
Contributory (Secondary): Rheumatic Fever
(Duration) 3 yrs. mos. ds.
(Signed) J. T. Patton M. D.
19 (Address) Paris Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs..mos..days. In the State..yrs..mos..days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Charles
DATE OF BURIAL: July 9 1916

20. UNDERTAKER: J. A. Blade
ADDRESS: St Charles

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14093
Registered No. .....

1. PLACE OF DEATH.
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6
Primary Registration District No. .....
(No. .... St.)

2. FULL NAME Evelyn Knox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. May (Month) 11 (Day) 1916 (Year)

7. AGE: — Yrs. 1 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: H. L. Knox

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Rosa E. Jobes

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. L. Knox
(Address) Emmett Ida

15. Filed 6/30 1916 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1916, to June 29 1916, that I last saw h[illegible] alive on June 28 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pneumonia, Bronchial
.....
.....
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Whooping Cough
(Duration ..... yrs ..... mos. 20 ds.
(Signed) J. L. Reynolds M. D.
6/30 1916 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 6/30 1916

20. UNDERTAKER: O. D. Bucknum — ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. 6
(No. ____ ____ St.)

File No. ____
Registered No. 1694

1. PLACE OF DEATH.
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK. DO NOT USE LEAD PENCIL. THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): widowed

6. DATE OF BIRTH. Nov (Month) 5 (Day) 1832 (Year)

7. AGE: 83 Yrs. 7 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): "

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Mc Cune

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C C Moore
(Address) Sh Cuchoney Ida

15.
Filed 6/18 1916 J. L. Reynolds Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1916, to June 14 1916, that I last saw h.e.s. alive on June 14 1916, and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Mitral insufficiency
(Duration) 3 years Yrs. ____ mos. ____ ds.
Contributory (Secondary) ____
(Duration ____ yrs. ____ mos. ____ ds.

(Signed) J. L. Reynolds M. D.
6/18 1916 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: June 18 1916

20. UNDERTAKER: C. D. Buckmun
ADDRESS: Emmett

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14695

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Elmore

City of Emmett

2. FULL NAME John W. Carmichael

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Mar (Month) 11 (Day) 1843 (Year)

7. AGE: 73 Yrs. 3 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Do not know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. W. Carmichael

(Address) Emmett Idaho

15.

Filed June 14 1916

J. L. Reynolds Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from occasionally Sometime in 1911 to June 10 1916, that I last saw him alive on June 10 1916; and that death occured on the date stated above, at 4:15 P. M.

The CAUSE OF DEATH* was as follows:

Epithelioma

..... (Duration) 2 Yrs. ? mos. — ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. H. Cummings M. D.

6/17 1916 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: June 12 1916

20. UNDERTAKER: C. D. Bucknum — ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Gem

City of Emmett

Registration District No. 6

Primary Registration District No.

(No. ..... St.)

File No. 14696

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Daphne Miller

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Apr (Month) 25 (Day) 1828 (Year)

7. AGE: 87 Yrs. 7 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Emmonds

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora Dennston

(Address) Emmett Idaho

15. Filed 6/8 1916 J. L. Reynolds Local Registrar

EVANS - YORK CO., PTGS. & ENGS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1916 to June 7 1916, that I last saw h-- alive on June 7 1916, and that death occured on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Apoplexia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Senility

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Reynolds M. D.

6/8 1916 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho City Idaho

DATE OF BURIAL: 6/9 1916

20. UNDERTAKER: C. D. Buckenum

ADDRESS: Emmett

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 192
County of Shoshone Primary Registration District No. 2208
City of Wallace (No. Wait Idaho St.)
File No. 14697
Registered No. 94

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac Pakkala

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 23 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber Worker
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Not Known

10. NAME OF FATHER: Arvid Pakkala

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clark
(Address) Wait Idaho

15. Filed 6/10 1916 W. C. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 8 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8 1916, to June 8 1916
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Struck by falling tree
+ Spinal Column fractured
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. R. Mowry Coroner M. D.
..... 19..... (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: June 10 1916

20. UNDERTAKER: [illegible] — ADDRESS: Wallace

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 1200
File No. 14698
Registered No. 73

1. PLACE OF DEATH.
County of Shoshone
~~City~~ of Mace
(Green Hill Cleveland Mine St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Mc. Isaac

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 25 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass.

10. NAME OF FATHER: Dan. J. Mc. Isaac

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. E. Ward
(Address) Wallace Ida

15. Filed 6/6 1916 H Cullom
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) June 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on May 31 1916,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Acute Dilatation of heart following a fatty degeneration of muscles
(Duration) 1 Yrs. 2 mos. 1 ds.
Contributory (Secondary) Mitral regurgitation
(Duration) ... yrs. ... mos. ... ds.
(Signed) Chas R. Mowrer Coroner
6/5 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence: Mace Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: June 6 1916

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SVSB - YORK CO., PTRS. & BOKS. 24653

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14699

Registered No.

1. PLACE OF DEATH.
County of Blaine
City of Fairfield
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58
Primary Registration District No. 2158
(No. ....., ... St.)

2. FULL NAME Thos Warren

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
— (Month) — (Day) 1? (Year)

7. AGE: 70 about yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): Ireland ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Ireland ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John L. Robertson
(Address) Fairfield Ida

15.
Filed 6-24 1916 D.O. Higgs Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1916, to June 23 1916
that I last saw him alive on June 20 1916,
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Acute Regurgitation
2 Valvular Heart disease

(Duration) 5 yrs. — mos. — ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D.O. Higgs M. D.
6-24 1916 (Address) Fairfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Soldier — DATE OF BURIAL: 6-24 1916

20. UNDERTAKER: Sig Mandl — ADDRESS: Fairfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RINDERS. BOISE 18672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5-8
Primary Registration District No. 2138
File No. 14700
Registered No.

1. PLACE OF DEATH.
County of Blaine
City of Soldier
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Avis Trowbridge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Girl	White	Single

6. DATE OF BIRTH: April (Month) 27 (Day) 1916 (Year)

7. AGE: yrs. 1 mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER L E Trowbridge

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Effie Ewell

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L E Trowbridge
(Address) Fairfield Ida

15. Filed 6-16 1916 D O Higgs Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27 1916, to June 15 1916, that I last saw her alive on June 15 1916, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Inanition

(Duration) yrs. 1 mos. 18 ds.
Contributory (Secondary) Premature birth
(Duration) yrs. mos. ds.

(Signed) Dewitt Higgs M. D.
6-16 1916 (Address) Fairfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Soldier — DATE OF BURIAL: 6-17 1916

20. UNDERTAKER: Ray Mould — ADDRESS: Fairfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. N[illegible] 6-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration Dis[illegible]

County of Oneida

Primary Registration District No.

File No. 14701

City of Burbett

(No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Norman Walter Horn.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) April (Day) 2 (Day) 1906 (Year)

7. AGE: 10 Yrs. 2 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At home.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wash. Whitman Co.

10. NAME OF FATHER: Christian O Horn

11. BIRTHPLACE OF FATHER (State or Country) Michigan

12. MAIDEN NAME OF MOTHER: Bertha Burns.

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Christian O Horn
(Address) Sublett Ida

15. Filed June 14 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 9. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1916, to June 9 1916, that I last saw h[illegible] alive on June 1 1916, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Rheumatism

(Duration) — Yrs. — mos. 10 ds.

Contributory (Secondary) mitral regurg.

(Duration) 1 yrs. — mos. — ds.

(Signed) C E Slater M. D.

6/14 1916 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. — mos. — days. In the State 6 yrs. — mos. — days
Where was disease contracted if not at place of death? At place of death.
Former or usual residence Washington

19. PLACE OF BURIAL OR REMOVAL: Sublett Ida. DATE OF BURIAL: June 6 1916

20. UNDERTAKER: L B Talbogly. ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce
City of Genesee

Registration District No. 62
Primary Registration District No. 242
(No. ....., ... St.)

File No. 14702
Registered No. 71

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily Joanna Struble

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: December 21 (Month) 1836 (Day) (Year)

7. AGE: 79 yrs. 5 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired farmers wife.
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York, Delaware Co.

10. NAME OF FATHER: Lyman Graves

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Laura Botsford

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. P. Michaelson
(Address) Genesee, Idaho.

15. Filed June 10th 1916 W. N. Sheen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 8 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1916, to June 7 1916
that I last saw her alive on June 7 1916
and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Cancer of liver
Carcinoma of liver
about two
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. F. Thurman M. D.
June 9 1916 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Plainview, Minn. DATE OF BURIAL: June 14 1916

20. UNDERTAKER: F. E. Lambert ADDRESS: Genesee Ida

ment of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Genesee

Registration District No. Spokane 62
Primary Registration District No. Palouse 7142
(No. ....., ... St.)

File No. 14703
Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Bernard Broemmeling

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: July 8 (Month) (Day) 1853 (Year)

7. AGE: 62 yrs. 11 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry business or establishment in which employed (or employer): retired

9. BIRTHPLACE (State or Country): Albany N. Y.

10. NAME OF FATHER: Roger Broemmeling

11. BIRTHPLACE OF FATHER (State or Country): Emerich Germany

12. MAIDEN NAME OF MOTHER: Anna Buchoff

13. BIRTHPLACE OF MOTHER (State or Country): Near Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs John Johann
(Address): Genesee Idaho

15. Filed June 22 1916 W. N. Coblentz Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar - 1 1916, to Apr 15 1916 that I last saw h[illegible] alive on May 15 1916 and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Dunn M. D.
June 19 1916 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cath. Cem.
DATE OF BURIAL: June 22 1916

20. UNDERTAKER: F. E. Lambert
ADDRESS: Genesee Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 10147

Registered No. 11

1. PLACE OF DEATH.

County of Cassia

City of Basin

Registration District No. 170

Primary Registration District No. 2199

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Enoch Dayley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 15 (Day) 1916 (Year)

7. AGE: ..... Yrs. ..... Mos. Hours ds.

IF LESS than 1 day how many 2 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm Enoch Dayley

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Hattie Hurst

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Enoch Dayley

(Address) Basin Idaho

15.

Filed 6-17 1916

E P Graham
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 - 830 1916, to ..... 191..., that I last saw him alive on June 15th - 9.30 1916, and that death occured on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Probable
Non Closure of Cardiac Torsion

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. W. Hoagson M. D.

6/17 1916. (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Basin Idaho | DATE OF BURIAL: 6-17 1916

20. UNDERTAKER: B. F. Sayers | ADDRESS: Basin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cassia
City of Oakley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 120
Primary Registration District No. 2199
(No. ....., ... St.)

File No. 11705
Registered No. 192

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Victor LeRoy Scharling

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 5 (Day) 1916 (Year)

7. AGE: ..... yrs. 1 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Parley Scharling

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Dena Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. M. Hansen
(Address) Oakley Idaho

15. Filed 6 / 26 1916 E. D. Oldham Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h~~e alive on~~ ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Probably
Marasmus (Ent)
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W D Attending M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho
DATE OF BURIAL: 6-26-1916

20. UNDERTAKER: W R Lee. ~~Dat~~
ADDRESS: Oakley Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint

Registration District No. 7 8
Primary Registration District No. 2153
(No. ....., ... St.)

File No. 11706
Registered No. 896

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Alberta Dyer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: June (Month) 12 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 30 hours ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho. Selpr.

10. NAME OF FATHER: Albert Henry Dyer

11. BIRTHPLACE OF FATHER (State or Country): Ontario

12. MAIDEN NAME OF MOTHER: Mary Ann Mead

13. BIRTHPLACE OF MOTHER (State or Country): Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. H. Jameson
(Address) Selpr

15.
Filed June 23 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from birth June 11 1916, to June 13 1916
that I last saw her alive on June 13 1916
and that death occurred on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:
Infantile debility-

..... (Duration) ..... yrs. ..... mos. 30 hours

Contributory (Secondary) Difficult labor. Forceps. Dystocia. Hydrocephalus. Caesarean Sec
..... (Duration) ..... yrs. ..... mos. 3 hrs ds.

(Signed) R. H. Jameson M. D.
..... 19 ..... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida
DATE OF BURIAL: June 13 1916

20. UNDERTAKER: C M Brower
ADDRESS: Sandpoint Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

Primary Registration District No. 213-5-

File No. 14708

Registered No. 896

County of Bonner

City of Sandpoint (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Matt Marks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

45 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G H Bray

(Address) Sandpoint

15.

Filed June 26 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 26 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 23 June 1916, to 26 June 1916, that I last saw him alive on 26 June 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Endocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O F Payne M. D.

19 ..... (Address) Sandpoint Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Idaho	June 27 1916

20. UNDERTAKER	ADDRESS
C M Brower	Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2155

File No. 14709

City of Sandpoint

(No. ....., ... St.)

Registered No. 897

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pleasant T. Hood

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 24 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Surveyor
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Mexico

10. NAME OF FATHER: E. R. Hood

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Tabor

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Hood

(Address) .....

15. Filed June 22 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 21 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1912, to June 15 1916, that I last saw him alive on June 15 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. McKinnon M. D.

June 22 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Idaho	June 22 1916
20. UNDERTAKER	ADDRESS
E M Brouner	Sp

If any, should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2155
File No. 14710
Registered No. 892

1. PLACE OF DEATH.
County of Bonner
City of Colburn (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carter

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: May (Month) 25 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Colburn Ida

10. NAME OF FATHER: Ira F Carter

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Mabel Halton

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed May 26 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1916, to May 25 1916, that I last saw h[er] alive on May 25 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Infantile Debility

(Duration) ..... yrs. ..... mos. 36 hours ds.
Contributory (Secondary) Marasmus Pneumonia Edema enough to produce extreme anemia
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. T. Jackson M. D.
19 ..... (Address) Deer

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Colburn Ida
DATE OF BURIAL: ..... 191..

20. UNDERTAKER: None
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 14-
Primary Registration District No.
File No. 14712
Registered No. 29

1. PLACE OF DEATH.

County of Boise
City of or Ranch (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bonita Vleen Ewert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 3 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norwood Ida

10. NAME OF FATHER: A J Ewert

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Minnie Colman

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gladys Bennett
(Address) McCall Ida

15.
Filed July 8 1916 Ruth McDaniel Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:

.....
.....
.....
.....(Duration) 3 Yrs. ... mos. ... ds.
Contributory (Secondary) .....
.....(Duration ... yrs. ... mos. ... ds.
(Signed) ..... M. D.
..... 19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? At home
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: McCall Ida. DATE OF BURIAL: June 16 1916
UNDERTAKER ..... ADDRESS .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STNRS. 24654

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14713

Registered No. 20

1. PLACE OF DEATH.

County of Boise

City of Banks

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME not named

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: X (Month) 19 (Day) 16 (Year)

7. AGE: yrs. mos. 6 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *min.?*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Geo Faulds

11. BIRTHPLACE OF FATHER (State or Country) no

12. MAIDEN NAME OF MOTHER Cora Scott

13. BIRTHPLACE OF MOTHER (State or Country) No

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. E. Noggle

(Address) Cascade Ida

15.

Filed July 8 1916

Mary A McDonald
Asst
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-19-24 1916, to 6-24 1916

that I last saw h[illegible] alive on 6-25 1916,

and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Congenital Goitre

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. E. Noggle M. D.

..... 19..... (Address) Cascade

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was Disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett

DATE OF BURIAL: 6-24- 1916

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 2181

File No. 14714

County of Idaho

City of Grangeville (No. ....., ... St.)

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George L Riebold.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH: June (Month) 25 (Day) 1877 (Year)

7. AGE: 38 yrs. 11 mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): Nevada Co, Cal.

10. NAME OF FATHER: Peter Riebold

11. BIRTHPLACE OF FATHER (State or Country): Hess Germany

12. MAIDEN NAME OF MOTHER: Katherine Longenwalter

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Sam Riebold
(Address): Grangeville Idaho

15. Filed July 3 1916 G S Elliston Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1916, to June 7 1916, that I last saw him alive on June 7 1916, and that death occurred on the date stated above, at 6.45 P.M.

The CAUSE OF DEATH* was as follows:
Accidental gunshot wound

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jesse L Rains M. D.
June 8 1916 (Address) Grangeville, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fair View	6/9 1916

20. UNDERTAKER	ADDRESS
F E Graham	Grangeville

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181
(No. ....., ... St.)

File No. 14715
Registered No. 20
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Della Nicholls Galvin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov 22 1872 (Month) (Day) (Year)

7. AGE: 43 yrs. 8 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE: Worn in County Iway (State or Country)

10. NAME OF FATHER: Eliott Nicholls

11. BIRTHPLACE OF FATHER: Oiho (State or Country)

12. MAIDEN NAME OF MOTHER: Sarah Saxton

13. BIRTHPLACE OF MOTHER: Indana (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jeff Galvin
(Address) Grangeville

15. Filed July 3 June 16 1916
GB Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 15 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1916 to June 15 1916 that I last saw her alive on June 15 1916 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
General Septicemia following infection in the kidneys + abscess of Parotid gland. (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) GB Stockton M. D.
6/16 1916 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prarie View — DATE OF BURIAL: June 17 1916

20. UNDERTAKER: W. E. GRaham — ADDRESS: Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 14716
Registered No. 52

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Weingartner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. January (Month) 26 (Day) 1832 (Year)

7. AGE: 84 Yrs. 6 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): 8 yrs. retired

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: John Weingartner

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Lourecia Butler

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. S. E. Weingartner
(Address) Caldwell, Ida.

15. Filed 7-7-1916 John O. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1916, to July 6 1916, that I last saw h.im alive on July 15 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ..... Yrs. one mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Gwyn M. D.

7/7 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 7/7 1916

20. UNDERTAKER: W. C. Dyer
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14717

Registered No. 54

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A Lucile Robison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Aug (Month) 6 (Day) 1895 (Year)

7. AGE: 20 Yrs. 8 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois.

10. NAME OF FATHER: W. S. Robisson.

11. BIRTHPLACE OF FATHER (State or Country): Indianna.

12. MAIDEN NAME OF MOTHER: Emily J. Mulholland

13. BIRTHPLACE OF MOTHER (State or Country): Indianna.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E L Robison
(Address) Caldwell Ida.

15. Filed 7-3- 1916

John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-19 1916, to 7-2 1916, that I last saw her alive on 7-2- 1916, and that death occured on the date stated above, at 11.55 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary) Pneumonia

(Duration ..... yrs. ..... mos. 2 ds.

(Signed) C M Caley M. D.

7-3 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: July 5 1916

20. UNDERTAKER: Peckham Co. ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYUS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 14718
Registered No. 50

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William J. Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): —

6. DATE OF BIRTH. July (Month) 16 (Day) 1913 (Year)

7. AGE: 2 Yrs. 11 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: — — —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Caldwell Idaho

10. NAME OF FATHER W. J. Carter

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Dora Sullenger

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dora Carter
(Address) Caldwell

15. Filed 6-26- 1916 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ son deceased from ..... 191 to 191,
that I last saw him alive on June 25 1916,
and that death occured on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:
Rupture of bloodvessle
Blood discharging from nose
(Duration) ..... Yrs. ..... mos. 1 hr. 30 ds. (J.S.M.)
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S. D. Miller M. D.
6-26-1916. (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs:.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: June 26 1916

20. UNDERTAKER: Jackman Case & Co. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14719

Registered No. 49

1. PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nancy A Rayfairs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 21 (Day) 1849 (Year)

7. AGE: 67 Yrs. 1 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: John Ellis

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M J. McConnell

(Address) Caldwell Ida

15. Filed 6-18- 1916 John S Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1916, to June 16 1916, that I last saw h[illegible] alive on June 12 1916, and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH was as follows*

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Arterio sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Guy M. D.

6/18 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Ridge — DATE OF BURIAL: June 17 1916

20. UNDERTAKER: W. C. Dyer — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. ..... St.)

File No. 14720
Registered No. 45

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gabrella Jordon Turley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Feb (Month) 4 (Day) 1844 (Year)

7. AGE: 72 Yrs. 2 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: James Simmons

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Goodall

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. J. Turley
(Address) Caldwell, Ida.

15. Filed 6-12 1916
John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1915, to June 11 1916, that I last saw her alive on June 11 1916, and that death occured on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH* was as follows:
Asthma.

(Duration) 10 Yrs. mos. ds.
Contributory (Secondary) Interstitial Nephritis

(Duration) several yrs. mos. ds.

(Signed) J. W. Lyerly & C. O. Bashor M. D.
6/12 1916 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida. DATE OF BURIAL: 191

20. UNDERTAKER: Peckham Co. Co. ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2170
(No. ....., ... St.)

File No. 14722
Registered No. 66
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maquillas Rodarte

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Mexican	

6. DATE OF BIRTH
? (Month) (Day) 1 (Year)

7. AGE
about 28 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) ?

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Dunwoody
(Address) Ida Falls

15.
Filed July 6 1916 Guy Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July 2 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Murder - Gun shot

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Dunwoody Coroner M. D.
7/ 1916 (Address) Ida Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ida Falls	7/3 1916

20. UNDERTAKER	ADDRESS
C E Dunwoody	Ida Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14723

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13
Primary Registration District No. 21-0
(No. ....., ... St.)

2. FULL NAME Otto Anderson

Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Nov (Month) 22 (Day) 1871 (Year)

7. AGE
44 yrs. 6 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Dinwoodey
(Address) Ida Falls

15.
Filed July 6 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Heart Lesion
Myocardial degeneration
Contributory Medical Attendance
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) P Leyfurnand M. D.
7/6 1916 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls, Ida — DATE OF BURIAL: June 1916

20. UNDERTAKER: C E Dinwoodey — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14724
Registered No. 47

1. PLACE OF DEATH.
Registration District No. 23
County of Bonneville
Primary Registration District No. Idaho
City of Idaho Falls (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Matilda E Beam

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed
6. DATE OF BIRTH: January (Month) 1 (Day) ..... (Year)
7. AGE: 61 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: ?
11. BIRTHPLACE OF FATHER (State or Country): ?
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (State or Country): ?
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Beam by CHG
(Address) Ida Falls
15. Filed May 6 1916 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 17 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916., to June 17 1916,
that I last saw her alive on June 17 1916
and that death occurred on the date stated above, at 1:10 M.
The CAUSE OF DEATH* was as follows:
Gastric Ulcer
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. S. Fuller M. D.
6/ 1916 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls
DATE OF BURIAL: 6/19/1916
20. UNDERTAKER: E E Linwood
ADDRESS: Ida Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Dr Fuller

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14725

Registered No. 63

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 72

Primary Registration District No. 2170

County of Bonneville

City of Idaho Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Akogy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 13 (Day) 1838 (Year)

7. AGE: 77 yrs. 6 mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer Eby

(Address) Idaho Falls Ida

15.

Filed July 6 1916 Coe Leonard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Unknown -
No medical attendance

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Coe Leonard M. D.

7/6 1916 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls

DATE OF BURIAL: 6/20 1916

20. UNDERTAKER: C E Dinwoody

ADDRESS: Idaho Falls

SYMS-YORK CO., PTRS. & SDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2150
(No. ..... St.)

File No. 14726
Registered No. 42

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hiram Lowe Kramer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
August (Month) 10 (Day) 1911 (Year)

7. AGE
1 Yrs. 10 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Iowa

10. NAME OF FATHER: Peter Kramer

11. BIRTHPLACE OF FATHER
(State or Country) Denmark

12. MAIDEN NAME OF MOTHER: Clara Lowe

13. BIRTHPLACE OF MOTHER
(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Peter Cramer
(Address) Idaho Falls R 2 - Idaho

15.
Filed 6/29 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
6/29 1916 (Address) Idaho Falls I.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iowa — DATE OF BURIAL: June 30 1916

20. UNDERTAKER: [illegible] Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

...GIN RESERVED FOR BINDING

SYMS - YORK CO., PTYS. & SUPS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14727

Registered No. 61

Registration District No. 13

Primary Registration District No. 2110

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls. (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John J. Smith.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Not Known. (Month) (Day) 1 (Year)

7. AGE: 63 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. O'Neill & Smith

(Address) Idaho Falls Ida.

15. Filed 6/25 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June E. 25 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1916, to June 25 1916, that I last saw him alive on June 25 1916, and that death occured on the date stated above, at 9. P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. P. Sederquist M. D.

6/27 1916 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Post Hill Town — DATE OF BURIAL: June 1916

20. UNDERTAKER: W. Ford — ADDRESS: Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2102
File No. 14728
Registered No. 40

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls
(No. Gen'l. Hosp. St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stratford E Buttars

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH: Oct 12 1914 (Month) (Day) (Year)

7. AGE: 1 yrs. 8 mos. 10 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James J. Buttars

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Agnes E Jardine

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas J Buttars
(Address) Ida Falls

15. Filed 6/26 1916 Geo Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 25 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1916, to June 25 1916, that I last saw h[illegible] alive on June 25 1916 and that death occurred on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows:
Intestinal Obstruction

(Duration) yrs. mos. 4 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) John McClard M. D.
19 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence Shipsaw[illegible]

19. PLACE OF BURIAL ~~OR REMOVAL~~: Cache Junction — DATE OF BURIAL: 6/26 1916

20. UNDERTAKER: E E Dunwoody — ADDRESS: Ida Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

Registration District No. 86

Primary Registration District No. 1010

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14729

Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Cyrus Galloway

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 6 (Month) 6 (Day) 1837 (Year)

7. AGE: 78 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer & Stock Raiser

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mineral Point Wis

10. NAME OF FATHER: Charles Galloway

11. BIRTHPLACE OF FATHER (State or Country): Shenandoah Valley, Virginia

12. MAIDEN NAME OF MOTHER: Mary Haney

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. W. Galloway

(Address) Weiser Idaho

15. Filed 6-7 1916

W. R. Hamilton
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5 (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1 1916, to June 5 1916, that I last saw h[illegible] alive on June 5 1916, and that death occured on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Chronic Bronchitis

(Duration 10 yrs. — mos. — ds.

(Signed) James A Young M. D.

June 7, 1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Portland, Ore — DATE OF BURIAL: 6-8 1916

20. UNDERTAKER: Wm McBratney — ADDRESS: Weiser

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
(No. ..... St.)

File No. 14730
Registered No. 29

1. PLACE OF DEATH.
County of Washington
City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Ryan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Oct. (Month) 2 (Day) 1837 (Year)

7. AGE: 78 Yrs. 8 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. L. Ryan
(Address) Weiser Idaho

15. Filed 6-28 1916 W. P. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Senility
No Evidence of foul play
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
Duration — yrs. 7 mos. ..... ds.
(Signed) James T. McCann M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho | DATE OF BURIAL: June 30 1916

20. UNDERTAKER: Northam & McCann | ADDRESS: Weiser Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14731
Registered No. 17

1. PLACE OF DEATH.
County of Franklin
City of Riverdale
(No. ....., ... St.)
Registration District No. 27
Primary Registration District No. 2119

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennie Folman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 11 (Day) 1885 (Year)

7. AGE: 30 Yrs. 7 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: General House work
(b) General nature of industry, business, or establishment in which employed (or employer): My own family

9. BIRTHPLACE (State or Country): Davis Co. Utah

10. NAME OF FATHER: Christen V. Call

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Minnie Barlow

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Judson Folman
(Address) Preston Idaho

15. Filed July 1 1916 Allen P. Cutler M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1916, to June 15 1916, that I last saw her alive on June 14 1916, and that death occured on the date stated above, at 10.45 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes Militus
Fr Diabetes Coma 36 hours
(Duration) Dont Know mos. ..... ds.
Contributory (Secondary) ✓
(Duration ✓ yrs. ..... mos. ..... ds.

(Signed) G. W. Stokes M. D.
Jan 6 1916 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days
In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston, Ida.
DATE OF BURIAL: 6-16 1916
20. UNDERTAKER: None.
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 97
Primary Registration District No. 2174.
(No. ..... St.)

File No. 14732
Registered No. .....

1. PLACE OF DEATH.
County of Nez Perce
City of Lapwai -
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William E. Ratcliff.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. January (Month) 28 (Day) 1848 (Year)

7. AGE: 71 Yrs. 4 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Butcher & Shoe maker
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Isaac Ratcliff.

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Hulda Carr.

13. BIRTHPLACE OF MOTHER (State or Country): Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Berrie Harrigan - (daughter)
(Address) Davenport. Wash.

15. Filed June 10 1916 William H. Hahn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1916, to June 9 1916; that I last saw h[illegible] alive on June 8 1916, and that death occured on the date stated above, at 8-a. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Arteriosclerosis.
(Duration) 5 Yrs. ..... mos. ..... ds.
(Signed) William H. Hahn M. D.
6/9 1916 (Address) Lapwai - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Culdesac - Idaho. DATE OF BURIAL: June 10 1916

20. UNDERTAKER: Mann Bros. ADDRESS: Lapwai.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNE - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 97
Primary Registration District, No. 2171
(No. Fort Lapwai Indian Sanitorium St.)

File No. 14733
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Nez Perce
City of Lapwais.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Ricketoff.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male.

4. COLOR OR RACE: Indian Alaskan.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single.

6. DATE OF BIRTH. (Month) — (Day) — (Year) 1903

7. AGE: 13 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alaska - Alas.

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): not known.

12. MAIDEN NAME OF MOTHER: Theodosia Teomyae

13. BIRTHPLACE OF MOTHER (State or Country): Alaska.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fort Lapwai Indian Sanitorium Records.
(Address) Lapwai Idaho.

15. Filed June 7 1916 William P. Hobel
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1916, to June 1 1916, that I last saw h[illegible] alive on June 1 1916, and that death occured on the date stated above, at 5 p. M.

The CAUSE OF DEATH* was as follows:
Tubercular Peritonitis

(Duration) — Yrs. 7 mos. — ds.
Contributory (Secondary) General Miliary T.B.
(Duration) 3 yrs. — mos. — ds.

(Signed) William P. Hobel M. D.
1916 (Address) Lapwai. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 7 yrs. 7 mos. 12 days. In the State 7 yrs. 7 mos. 10 days
Where was disease contracted if not at place of death? Alaska.
Former or usual residence Tacoma. Wash.

19. PLACE OF BURIAL OR REMOVAL: Tacoma. Wash.
DATE OF BURIAL: June 3 1916

20. UNDERTAKER: Mann & Mann
ADDRESS: Lapwai. Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 19

Primary Registration District No. 2015

File No. 14734

County of Minidoka

City of Rupert (No. ....., ... St.)

Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John C Weiner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 24 (Day) 1862 (Year)

7. AGE: 53 Yrs. 9 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wigan Mfg
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Bohemia

10. NAME OF FATHER Frank Weiner

11. BIRTHPLACE OF FATHER (State or Country) Bohemia

12. MAIDEN NAME OF MOTHER Elizabeth Penkava

13. BIRTHPLACE OF MOTHER (State or Country) Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jennie Weiner
(Address) Portland Ore.

15. Filed June 12 1916 E. H. Tallmon Local Registrar

BYRNS PRINT CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-16 1916, to 4-17 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C P Lucas M. D.

4-31 1916 (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho — DATE OF BURIAL: Apr 20 1916

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

DINWIDDIE CONSTRUCTION CO.

SAN FRANCISCO, CALIFORNIA

ADDRESS ALL COMMUNICATIONS
TO THE COMPANY

November 29, 1937.

State of Idaho,
Department of Public Welfare,
Bureau of Vital Statistics,
Boise, Idaho.

Gentlemen:

I wish to correct an error made in the death certificate of my father John Charles Weiner, who passed away in Rupert, Idaho, April 17, 1916.

The correction is his mother's maiden name which should read - "Elizabeth Penkava". Its a Bohemian name and I got it all wrong at the time of filling out the certificate. I will greatly appreciate having you correct this name on the death certificate. Please let me know the charges and I will reimburse you immediately.

Yours very truly,

Jennie Weiner

Jennie Weiner, 210 Crocker Bldg.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 14735
Registered No. 15

1. PLACE OF DEATH.
County of Minidoka
City of Rupert
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gladys Hunting

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH.
Sept (Month) 1 (Day) 1916 (Year)

7. AGE
Yrs. 9 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Shelley Idaho

10. NAME OF FATHER: Ruben Hunting

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ethel Eden

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ruben Hunting
(Address) Rupert Idaho

15.
Filed 7 - 8 1916
E H Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1916, to June 9 1916, that I last saw her alive on June 7 1916, and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Atelectasis
(Duration ..... yrs. 9 mos. ..... ds.
(Signed) E H Elmore M. D.
19 ..... (Address) Rupert, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I O O F Cemetery — DATE OF BURIAL: June 10 1916

20. UNDERTAKER: W. C. Goodman — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BOOK. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14736

Registered No. 16

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

(No. ....., ... St.)

Registration District No. 19

Primary Registration District No. 2015

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet Donnaldson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Mar (Month) 17 (Day) 1835 (Year)

7. AGE: 81 Yrs. 1 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): —

10. NAME OF FATHER: Joseph Donnaldson

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Harriet Hunt

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Burgess

(Address) Rupert Idaho

15. Filed 7 - 7 1916

E. H. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 8 1916, to Apr 19 1916, that I last saw h[illegible] alive on Apr 19 1916, and that death occured on the date stated above, at 5.00 M.

The CAUSE OF DEATH* was as follows:

Heart failure and aged

(Duration) [illegible] Yrs. [illegible] mos. 7 ds.

Contributory (Secondary) Several years de

(Duration) [illegible] yrs. [illegible] mos. ..... ds.

(Signed) [illegible] M. D.

19..... (Address) W. J. Rowland

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: 4-22 1916

20. UNDERTAKER: W A Goodman — ADDRESS: Rupert Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYRO - YORK CO., PTRS. & BOOK. 24053

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2615
(No. ....., ... St.)

File No. 14737
Registered No. 77

1. PLACE OF DEATH.
County of Minidoka
City of Rupert

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Horace McClure

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Nov (Month) 26 (Day) 1851 (Year)

7. AGE: 65 Yrs. 7 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Ranche

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Clark McClure

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER " "
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Myrtle Calene
(Address) Denver Colo

15.
Filed 7 - 7 1916
E H Erhart
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1916, to June 4 1916, that I last saw h[illegible] alive on June 4 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Nephritis
(Duration) Yrs. 2 mos. ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J B Kennedy M. D.
7/7 1916 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oaktown Ind — DATE OF BURIAL: 6-8 1916

20. UNDERTAKER: W R Goodman — ADDRESS: Rupert Ida

BYRNE - YORK CO., PTRS. & BKBS. 24655

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2007

File No. 14738

City of ..... (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Burt Leland Raymond

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH: Nov 17 (Month) 1914 (Day) (Year)

7. AGE: 1 yrs. 6 mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canyon Co

10. NAME OF FATHER Burt H Raymond

11. BIRTHPLACE OF FATHER (State or Country) Minn

12. MAIDEN NAME OF MOTHER Ora DeVault

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jos. Callaway
(Address) .....

15. Filed June 5 1916 Lulu Waldron Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 4 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1916., to June 4 1916, that I last saw h[illegible] alive on June 4 1916, and that death occurred on the date stated above, at 5-30 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculer Meningitis

(Duration) — yrs. — mos. 6m ds.

Contributory (Secondary) .....
(Duration) — yrs. — mos. — ds.

(Signed) T. B. Mulcahy M. D.
19.... (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parma | DATE OF BURIAL: 6-6 1916

20. UNDERTAKER: Peckham Case | ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14 14739
Registered No.

1. PLACE OF DEATH
County of Idaho
City of Cottonwood
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Richard Wita Oldham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 19 (Day) 1898 (Year)

7. AGE: 18 yrs. 2 mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Joseph Oldham

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Myra King

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas Oldham
(Address) Cottonwood

15.
Filed June 27 1916
H Bosler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1916, to May 31 1916 that I last saw him alive on May 31 1916 and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:
Accelerative Epilepsy

(Duration) ..... yrs. 1 mos. ..... ds.
Contributory (Secondary): Hemiplegia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Healey F Orr M. D.
June 26 1916. (Address) Cottonwood

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glenn
DATE OF BURIAL: 6/28 1916

20. UNDERTAKER: A H Kane
ADDRESS: Cottonwood

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake. Registration District No. 52.
City of Montpelier (No. ....., ... St.) Primary Registration District No. 2136.
If death occurs away from usual residence, give facts called for under special information.

File No. 14740
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myrtle Stewart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec 9th 1904 (Month) (Day) (Year)

7. AGE: 11 yrs. 6 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: John C. Stewart

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Sarah Floyd.

13. BIRTHPLACE OF MOTHER (State or Country): Farmington Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Glenn Stewart
(Address) Montpelier Idaho

15. Filed June 12th 1916. N. H. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 11.20 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Measles
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo. F. Eccles M. D.
19.... (Address) Montpelier Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Woodbow — DATE OF BURIAL: June 12th 1916.

20. UNDERTAKER: A. W. Dennis — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14741

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bear Lake

City of Montpelier

(No. , St.)

Registration District No. 52

Primary Registration District No. 2136

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Genevieve Phelps

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb. 27th 1914
(Month) (Day) (Year)

7. AGE: 2 yrs. 3 mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ezra Phelps.

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Jenny Roberts

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ezra Phelps.

(Address) Montpelier

15. Filed June 14th 1916 W. W. King Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 13 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1916, to May 13 1916, that I last saw her alive on May 13 1916, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobaris

(Duration) yrs. mos. ds.

Contributory (Secondary) Measles

(Duration) yrs. mos. ds.

(Signed) Geo F Oakley M. D.

May 13 1916 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier

DATE OF BURIAL: June 14 1916

20. UNDERTAKER: Larsen

ADDRESS: Montpelier

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 14712
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Franklin French Jr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Child.

6. DATE OF BIRTH
June (Month) 11 (Day) 1916 (Year)

7. AGE
1 yrs. 4 mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Child.
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Bear Lake Idaho

10. NAME OF FATHER Franklin French.

11. BIRTHPLACE OF FATHER
(State or Country) Montpelier Idaho.

12. MAIDEN NAME OF MOTHER Margarete Long.

13. BIRTHPLACE OF MOTHER
(State or Country) Cheyenne Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Lynn M.D.
(Address) Montpelier Idaho

15.
Filed June 11th 191 N. Nelson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1916, to June 11 1916, that I last saw him alive on June 11 1916, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Measles.

(Duration) yrs. mos. 7 ds.
Contributory (Secondary) Cerebral Hemorrhage Possibly from Kidney.
(Duration) yrs. mos. 1 ds.

(Signed) J. H. Lynn M. D.
June 11 1916 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Montpelier Idaho — DATE OF BURIAL 6/13/1916

20. UNDERTAKER T. Tarbach — ADDRESS Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 57
Primary Registration District No. 2136
(No. ....., ... St.)

File No. 14743
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ora Helen Herschie

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Jan. (Month) 28th (Day) 1912 (Year)

7. AGE: 4 yrs. 4 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Geneva Ida.

10. NAME OF FATHER: Otto Herschie

11. BIRTHPLACE OF FATHER (State or Country): Germany Europe

12. MAIDEN NAME OF MOTHER: Freda Emma Cleya Lusher

13. BIRTHPLACE OF MOTHER (State or Country): Germany Europe

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. W. Lynn
(Address) Montpelier Ida.

15. Filed June 16 1916. J. H. Kemp Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22nd 1916, to June 16th 1916, that I last saw her alive on June 16th 1916 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Obstruction of the bowels following a ruptured appendix
(Duration) ..... yrs. ..... mos. 25 ds.
Contributory (Secondary): none
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. W. Lynn M. D.
June 16 1916 (Address) Montpelier Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida. DATE OF BURIAL: June 16 1916

20. UNDERTAKER: Barbach ADDRESS: Montpelier

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14744

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of Filer

Registration District No. 38

Primary Registration District No. 2086

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Bolger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. X June (Month) 1st (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 7 hours ds.

IF LESS than 1 day how many ..... hrs. or 7 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wm R. Bolger

11. BIRTHPLACE OF FATHER (State or Country) Auburn, N.Y.

12. MAIDEN NAME OF MOTHER Eva G. Smith

13. BIRTHPLACE OF MOTHER (State or Country) Quincy Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm R Bolger

(Address) Filer

15. Filed 6-5 1916 A. A. Newberry Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1916, to June 4, 1916, that I last saw h[illegible] alive on June 4 1916, and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:

Pulmonary Atelectasis

7 hours (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

7 hours (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas D McGinnis M. D.

6/4 1916 (Address) Filer Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Cemetery — DATE OF BURIAL: June 5 1916

20. UNDERTAKER: E Drake — ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of ... (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 3086

File No. 14715
Registered No. ...

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Hulett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 15 (Day) 1870 ~~69~~ (Year)

7. AGE: 45 Yrs. 1 Mos. 1 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Ben E. Hulett

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Nancy White

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. W. G. Hulett (Sister)
(Address) Buhl Idaho

15. Filed June 19 1916 — 99 Newberry — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1916, to June 15 1916, that I last saw h in alive on June 15 1916, and that death occured on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:
Fracture at base of skull.
Caused by automobile accident
5 hours.
(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration ... yrs. ... mos. ... ds.

(Signed) Chas. Wilhelm M. D.
6/17 1916 (Address) Buhl Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Buhl
DATE OF BURIAL: 6-19 1916

20. UNDERTAKER: O. J. Crosby
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14746

Registered No. ____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of Dubois

Registration District No. 125

Primary Registration District No. ____

(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 30 (Day) 1916 (Year)

7. AGE ____ Yrs. ____ Mos. ____ ds.

IF LESS than 1 day how many ____ hrs. or 2 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Dubois Idaho

10. NAME OF FATHER Jas McGaddie

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary E Hunter

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas M Gaddie

(Address) Dubois Idaho

15. Filed July 1 1916

C E Jones M D
Local Registrar

SYMS - YORK CO., PTRS. & STNR. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 191__, to ____ 191__, that I last saw h__ alive on ____ 191__, and that death occured on the date stated above, at 10:12 P M.

The CAUSE OF DEATH* was as follows:

Premature Birth
6 Mos

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) C E Jones M. D.

7-1-1916 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Dubois Idaho — DATE OF BURIAL: July 1 1916

20. UNDERTAKER: Moul — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14747

Registered No. 3

1. PLACE OF DEATH.

County of Fremont

City of Dubois

Registration District No. 125

Primary Registration District No.

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ~~X~~ 4. COLOR OR RACE Male White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 30 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 2 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Dubois Idaho

10. NAME OF FATHER Jas McGaddie

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary E Hunter

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas McGaddie

(Address) Dubois Idaho

15.

Filed July 1 1916 C E Jones M d Local Registrar

SYMS - YORK CO., PTRS. & SOLS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at 10 o'clock P.M.

The CAUSE OF DEATH* was as follows:

Immature Birth

6 mos

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) C E Jones M. D.

7-1-1916 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~ Dubois Idaho — DATE OF BURIAL July 1 1916

20. UNDERTAKER None — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 14718
Registered No. 13

1. PLACE OF DEATH.
County of Boise
City of Horseshoe Bend

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amy Esther Freeman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Jan (Month) 27 (Day) 1870 (Year)

7. AGE: 46 Yrs. 5 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: do not know

11. BIRTHPLACE OF FATHER (State or Country): do not know

12. MAIDEN NAME OF MOTHER: do not know

13. BIRTHPLACE OF MOTHER (State or Country): do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jack Benton
(Address) Horseshoe Bend

15. Filed July 5 1916 — E Vadney, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1916, to July 4 1916, that I last saw her alive on June 28 1916, and that death occured on the date stated above, at 5 15a M.

The CAUSE OF DEATH* was as follows:
Oldage
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Paralysis
(Duration) ..... yrs. 3 mos. — ds.
(Signed) A. Skiffen M. D.
19.... (Address) Lubec, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Horseshoe Bend
DATE OF BURIAL: 7-6-1916

20. UNDERTAKER: Jack Benton
ADDRESS: Horseshoe Bend

STUB - YORK CO., PTRS. & BKBS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 12749
Registered No. 442

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 656 W Lander St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melva Brown

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. March 22 1906 (Month) (Day) (Year)

7. AGE: 9 Yrs. 9 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bannock Co. Idaho.

10. NAME OF FATHER Fred W Brown

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Ida B Wakley

13. BIRTHPLACE OF MOTHER (State or Country) Downey Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F W Brown
(Address) Pocatello Ida

15. Filed Jan 7, 1916 O B Lieser Local Registrar

SYMS - YORK CO., PTGS. & BDG. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1915, to Jan 6 1915, that I last saw her alive on Jan 5 7 P M 1916, and that death occured on the date stated above, at 7a. M.

The CAUSE OF DEATH* was as follows:
Endocarditis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Pneumonia

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. E. Walker M. D.

Jan 6th 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida. DATE OF BURIAL: Jan 7 1916

20. UNDERTAKER: Larkin + Sons Co ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9475

Registered No. 443

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2161

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samual G Short

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Not Known (Month) (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Gustav Short

11. BIRTHPLACE OF FATHER (State or Country): North Dakota

12. MAIDEN NAME OF MOTHER: Minah Smith

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J B Smith

(Address) Pocatello Ida.

15. Filed 3-25- 1916 O B Steely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 23 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1- 1916, to March 23 1916, that I last saw him alive on March 23 1916, and that death occured on the date stated above, at 2a M.

The CAUSE OF DEATH* was as follows:

Thrombus of Coronary Hemorrhage of Lungs

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Mar 25 1916 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Thatcher Idaho	Mar 26 1916
20. UNDERTAKER	**ADDRESS**
Larkin & Sons Company	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. '24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1951

Registered No. 947

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. Gen Hospital St.)

Registration District No. 84

Primary Registration District No. 2961

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sing Sung

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Chinaman

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Exact date unknown 1856
(Month) (Day) (Year)

7. AGE: 60 Yrs. Mos. ds. Near as known

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Waiter in
(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ah Kee
(Address) Pocatello

15. Filed Apr 24 1916 O B Sandy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Apr. 12th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 11 1916 to Apr 12 1916, that I last saw him alive on Apr 12 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Nephritis

(Duration) Yrs. mos. ds.

Contributory (Secondary) Tuberculosis

(Duration) yrs. mos. ds.

(Signed) L. Smith M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem- | DATE OF BURIAL: April 21 1916

20. UNDERTAKER: Schumacher & Hay | ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho,
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9-1752

Registered No. 1748.

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2961

(No. 218 N 2nd Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter A. Samuels

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH. Exact Date unknown 1861
(Month) (Day) (Year)

7. AGE: 55 Years ..... Mos. ..... ds.
Near as known
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Porter in
(b) General nature of industry, business, or establishment in which employed (or employer): Barber Shop.

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Rev Henry Mathews
(Address) Pocatello Ida.

15. Filed Apr 18, 1916 O B Dees Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 16th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1916, to April 16 1916, that I last saw h~~im~~ alive on April 16 1916, and that death occured on the date stated above, at about 5 P.M.

The CAUSE OF DEATH* was as follows:
Organic heart disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Arrowsmith M. D.

4/16 1916 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Ida — DATE OF BURIAL: April 19 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 914753

Registered No. 449

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

(No. Pocatello Gen Hospital St.)

2. FULL NAME Andrew Pappas

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Greek

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Exact date unknown 1881 (Month) (Day) (Year)

7. AGE: 35 Yrs. ..... Mos. ..... ds. (Near as Known)

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Greece

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Pappas
(Address) Pocatello

15. Filed Apr 21 1916 O B Steed Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 18th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 18 191 ..., to Apr 18 191 6
that I last saw h..... alive on ..... 191 ...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Malaria
Emphysema of Lungs
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) O Myrto Greece M. D.
Apr 21 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: April 21 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: City

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. ....., ... St.)

File No. 9475
Registered No. 450

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock
City of McCammon

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John B. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.
April (Month) ..... (Day) 1878 (Year)

7. AGE
38 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. Barber on
(b) General nature of industry, business, or establishment in which employed (or employer)..... Miner

9. BIRTHPLACE
(State or Country) Grant County Ore

10. NAME OF FATHER
Calvin Smith

11. BIRTHPLACE OF FATHER
(State or Country) Penns

12. MAIDEN NAME OF MOTHER
Don't Know

13. BIRTHPLACE OF MOTHER
(State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. M. Still
(Address) Hayburn Ida.

15.
Filed Apr 27 1916
O P Deeds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Accidentally Killed by Bear

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James A Porter M. D.
19... (Address) Conner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hayburn Ida.	April 27 1916
20. UNDERTAKER	**ADDRESS**
Larkin & Sons Co	Pocatello.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOK. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 9-1455
Registered No. 1457

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 422 - So Arthur St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Da Esterig Matthews

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. February (Month) 19 (Day) 1916 (Year)

7. AGE: Yrs. 2 Mos. 6 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo W. Mathews

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Imilda Flood

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo W. Matthews
(Address) 422 S. Arthur

15. Filed April 25, 1916 — O. R. Neely, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20 1916, to Apr 25 1916, that I last saw him alive on Apr 25 11 1916 and that death occured on the date stated above, at 9:36 a. M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Whooping Cough
(Duration) yrs. mos. ds.
(Signed) H A Castle M. D.
Apr 25 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem Pocatello Ida. — DATE OF BURIAL: April 27 1916
20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 14759
Registered No. 446

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 711 N. Harrison St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Hatton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. June (Month) 3rd (Day) 1827 (Year)

7. AGE 88 Yrs. 9 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired Machinist
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Thos Hatton

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Stuff

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas. E. Adamson
(Address) 818 N. Arthur Ave.

15. Filed April 14 1916 C. T. Deed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 11th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3 1916, to Apr. 11 1916, that I last saw h/m alive on Apr. 11 1916 and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Uremia
(Duration) Yrs. mos. 8 ds.
Contributory (Secondary) Nephritis
(Duration One yrs. mos. ds.

(Signed) W. J. Howard M. D.
4/13 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mountain View Cem. — DATE OF BURIAL April 15 1916

20. UNDERTAKER Schumacher & Hall — ADDRESS Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNS - YORK CO., PTRS. & SONS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161

File No. 9-A757
Registered No. 494

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 960 N. Hayes St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Lois Lambing

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Feb. (Month) 11 (Day) 1916 (Year)

7. AGE
1 Mo. 21 Yrs. Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Pocatello

10. NAME OF FATHER
I. S. Lambing

11. BIRTHPLACE OF FATHER
(State or Country) Iowa.

12. MAIDEN NAME OF MOTHER
Emma Reeves.

13. BIRTHPLACE OF MOTHER
(State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) I. S. Lambing
(Address) Pocatello

15.
Filed Apr 4, 1916
O. F. Reed
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from birth 2-11 1916, to 4-3 1916, that I last saw her alive on 4-3 1916, and that death occured on the date stated above, at 4.12 P M.

The CAUSE OF DEATH* was as follows:
Broncho-pneumonia

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) [illegible] M. D.
4/3 1916 (Address) Pocatello Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello Ida.	April 4 1916
20. UNDERTAKER	ADDRESS
Larkin & Sons C	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9 11760

Registered No. 11760.

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Fish

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word): Single

6. DATE OF BIRTH. (X) May (Month) 21 (Day) 1916 (Year)

7. AGE: ..... Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: William J. Fish

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Bessie Dougherty

13. BIRTHPLACE OF MOTHER (State or Country): Vermont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William J. Fish

(Address) 712 S. Hayes,

15. Filed May 25, 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21 1916, to May 23 1916, that I last saw him alive on May 23 1916, and that death occured on the date stated above, at 1.30 P M

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Colostrum from mothers milk

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

5/24 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello Ida	May 24 1916
20. UNDERTAKER	ADDRESS
Larkin & Sons Co	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 14761
Registered No. 753

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Estelle L Kerr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
July (Month) 12 (Day) 1860 (Year)

7. AGE
55 Yrs. 9 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) New York Broom Co

10. NAME OF FATHER: B A Potter

11. BIRTHPLACE OF FATHER
(State or Country) New York

12. MAIDEN NAME OF MOTHER: Elizabeth Byrnes.

13. BIRTHPLACE OF MOTHER
(State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo Kerr
(Address) Pocatello Idaho

15.
Filed May 3, 1916
O F Reed
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/1, 1913, to 5/1, 1916, that I last saw her alive on 4/28, 1916, and that death occured on the date stated above, at 7:45 P. M.

The CAUSE OF DEATH* was as follows:

Transverse Myelitis

(Duration) 4 Yrs. 1 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W A Lerwigh M. D.
5/x 1916 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello — DATE OF BURIAL: May 3 1916

20. UNDERTAKER: Larkin & Sons Co — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock — Registration District No. 84

City of Pocatello — Primary Registration District No. 2161

(No. ....., ... St.)

File No. 8476

Registered No. 455

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William J. Ham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write one word.): Single

6. DATE OF BIRTH. June (Month) 1 (Day) 1914 (Year)

7. AGE: 1 Yrs. 11 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Geo. W. Ham

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Mary E Rogers

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed May 8, 1916 — O B Steele, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 1916, to May 7 1916, that I last saw him alive on May 7 1916, and that death occured on the date stated above, at 9P M.

The CAUSE OF DEATH* was as follows:

Scarletina Anginsa

(Duration) — Yrs. — mos. 17 ds.

Contributory (Secondary) Insufflation Pneumonia

(Duration) — yrs. — mos. 3 ds.

(Signed) W. J. Howard M. D.

5/8 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho — DATE OF BURIAL: May 8 1916

20. UNDERTAKER: Larkin & Sons Co. — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNG - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 216
File No. 9476
Registered No. 456

1. PLACE OF DEATH.

County of Bannock
City of Pocatello
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Carr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Don't Know 1
(Month) (Day) (Year)

7. AGE: About 50 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Junk Dyer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Don't Know

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fly Kingdon
(Address) Pocatello Ida

15.
Filed May 20 1916
A B Steely
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 15 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Electrocuted Accidentally

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Francis A Poole M. D.
19.... (Address) Coroner.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake Ut. DATE OF BURIAL: May 2 1916

20. UNDERTAKER: Larkin & Sons ADDRESS: Poc. Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BOBB. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9 45764
Registered No. 457

1. PLACE OF DEATH.
County of Bannock
City of Fort Hall Dist. Sam Penguich ranch
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. ....., ... St.)

2. FULL NAME Frank Perry or Sego

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Red
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March 1st 1876 (Month) (Day) (Year)

7. AGE: 40 yrs. 2 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Forman Co., Wyoming

10. NAME OF FATHER: John St Clare

11. BIRTHPLACE OF FATHER (State or Country): Wyoming

12. MAIDEN NAME OF MOTHER: Dawsinetse

13. BIRTHPLACE OF MOTHER (State or Country): Forman Co, Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Welders
(Address) Fort Hall, Idaho

15. Filed May 22 1916 — O B Steely, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 18th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 1916, to May 18 1916, that I last saw him alive on May 17 1916 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Due to Gunshot of brain Revolver shot fired by Self with Suicidal intent of Party now deceased Frank Perry or Sego
(Duration) ..... yrs. ..... mos. ..... ds.
Death took place in 5 minutes.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry A Wheeler M. D.
May 20 1916 (Address) Fort Hall Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fort Washikee Wyo — DATE OF BURIAL: May 24 1916
20. UNDERTAKER: Larkin-Sons Co — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 914

Registered No. 458

1. PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

County of Bannock

City of Pocatello (No. 850 North Tenth St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eldon Irving Woffinden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH.

May (Month) 26 (Day) 1915 (Year)

7. AGE

..... Yrs. 1 1 Mos. 2 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Child

(b) General nature of industry, business, or establishment in which employed (or employer)... —

9. BIRTHPLACE (State or Country) Idaho Bannock Co

10. NAME OF FATHER Maurice Woffinden

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Abraina Norton

13. BIRTHPLACE OF MOTHER (State or Country) Idaho Falls Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maurice Woffinden

(Address) Pocatello Ida.

15.

Filed May 22 1916. [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 26 1916, to May 21 1916, that I last saw h[illegible] alive on Morning of May 21 1916, and that death occured on the date stated above, at 1:30 A. M.

The CAUSE OF DEATH* was as follows:

Laryngeal Stridulus

(Duration) several weeks Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Enteritis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. M. Kay M. D.

19..... (Address) Pocatello, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lincoln Idaho. DATE OF BURIAL: May 24 1916.

20. UNDERTAKER: Schumacher & Hall. ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 54
Primary Registration District No. 2161
(No. ....., ... St.)

File No. 9 14766
Registered No. 1459

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isham B Hodson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH.
Jan (Month) 9 (Day) 1834 (Year)

7. AGE
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Wain Co Kentucky

10. NAME OF FATHER
Eli Hodson

11. BIRTHPLACE OF FATHER
(State or Country) West Virginia

12. MAIDEN NAME OF MOTHER
Bennett

13. BIRTHPLACE OF MOTHER
(State or Country) West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Pocatello
(Address) J. F. Hodson

15.
Filed May 25 1916
O F Rees
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1916, to May 15 1916, that I last saw him alive on May 15 1916, and that death occured on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) Yrs. 2-3 mos. ..... ds.
Contributory (Secondary) Nephritis
(Duration ..... yrs. one mos. ..... ds.

(Signed) A M Newton M. D.
May 24 1916 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida
DATE OF BURIAL: May 26 1916
20. UNDERTAKER: Larkin & Sons
ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9767
Registered No. 1761

1. PLACE OF DEATH.

Registration District No. 84
Primary Registration District No. 2644
County of Bannock
City of Pocatello
(No. E. Clark Street St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oscar B. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Exact date unknown (Month) (Day) 1871 (Year)

7. AGE: 45 Years ..... Mos. ..... ds. Near as known

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): Elks Club

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Sidney Smith

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry Matthews
(Address) Pocatello Idaho

15. Filed May 29 1916 — O. B. Healy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1916, to May 26 1916, that I last saw him alive on May 25 1916, and that death occured on the date stated above, at 8.30 P.M.

The CAUSE OF DEATH* was as follows:
Embolism of brain
2 min
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Rheumatism
(Duration 5 yrs. ..... mos. ..... ds.

(Signed) J. Sherwood M. D.
5/29/1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: May 29 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

SYMS - YORK CO., PTRS. & BORS. 24654

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 9 14768
Registered No. 1762

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herbert Pannel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Married, Widowed or Divorced)
6. DATE OF BIRTH: January (Month) 21 (Day) 1908 (Year)
7. AGE: 8 Yrs. 4 Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Hawkins Ida
10. NAME OF FATHER: Thomas Pannel
11. BIRTHPLACE OF FATHER (State or Country): North Carolina
12. MAIDEN NAME OF MOTHER: Hannal Arntsen
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hannah Pannel
(Address) Hawkins Ida
15. Filed May 28, 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 1 1916 to May 27 1916, that I last saw h[illegible] alive on May 27 1916 and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Tbc Cerebral
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hawkins Ida — DATE OF BURIAL: May 30 1916
20. UNDERTAKER: Larkin & Sons Co — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTGS. & ENGS. 24055

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. ....., ... St.)

File No. 9769
Registered No. 764

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida B. Featherston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March 4th 1888 (Month) (Day) (Year)

7. AGE: 28 Yrs. 2 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Indefee

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Josephine Kelley

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. J. Featherston
(Address) Arbon Idaho

15. Filed May 29 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 28 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1916, to May 28 1916, that I last saw her alive on May 27 1916, and that death occured on the date stated above, at 6.45 P.M.

The CAUSE OF DEATH* was as follows:
Puerperal Septicemia
about (Duration) ..... Yrs. 2 mos. ..... ds.
Contributory (Secondary) Phlegmasia alba Dolens
(Duration ..... yrs. ..... mos. 20 ds.

5/29 (Signed) C. F. Schick M. D.
1916 (Address) American Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dunlap Kansas — DATE OF BURIAL: May 31 1916

20. UNDERTAKER: Schumacher & Hay — ADDRESS: City

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84
Primary Registration District No. 2141
(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9477
Registered No. 466

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Anna Methias

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (strike out the words not required)
6. DATE OF BIRTH: Not Known (Month) (Day) (Year)
7. AGE: about 70 years. ..Yrs. ..Mos. ..ds.
IF LESS than 1 day how many ..hrs. or ..min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Wales
10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (State or Country): Wales.
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (State or Country): Wales
14. I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. M. Knowles
(Address) Pocatello
15. Filed May 31 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 1916, to May 31 1916, that I last saw h.. alive on May 29 1916, and that death occured on the date stated above, at 3½ P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia. Lobular
Burns on body.
..(Duration) ..Yrs. ..mos. ..ds.
Contributory (Secondary)
..(Duration) ..yrs. ..mos. ..ds.
(Signed) [illegible] M. D.
May 31 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs. ..mos. ..days. In the State ..yrs. ..mos. ..days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello — DATE OF BURIAL: May 31 1916
20. UNDERTAKER: Parkins & Sons Co — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of .....

Registration District No. 84
Primary Registration District No. 2161
(No. ....., ... St.)

File No. 9 14771
Registered No. 76 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rose Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Red
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April (Month) 15th (Day) 1865 (Year)

7. AGE: 51 yrs. 1 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Thomas LaVatta

11. BIRTHPLACE OF FATHER (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Nelson
(Address) Pocatello R F D No 1

15. Filed May 31 1916 — O P Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 30th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1916, to May 30 1916, that I last saw her alive on May 29 1916 and that death occurred on the date stated above, at 1.30 P M.

The CAUSE OF DEATH* was as follows:

Uterine Cancer

..... (Duration) 1 yrs. — mos. — ds.

Contributory (Secondary) Uterine Hemorrhage

— (Duration) — yrs. 1 mos. 15 ds.

(Signed) Henry R Wheeler M. D.
June 2 1916 (Address) Fort Hall, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello
DATE OF BURIAL: June 2 1916

20. UNDERTAKER: Larkin & Sons
ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 84
Primary Registration District No. 2161
(No. ..... St.)

File No. 9 14772
Registered No. 1168

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John H. Powell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH.
Aug (Month) 15 (Day) 1847 (Year)

7. AGE
69 Yrs. 9 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wales

10. NAME OF FATHER John H. Powell

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER Cecilia Prossar

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Jessie aka
(Address) Mrs O A Powell

15. Filed June 1, 1916 E. E. Rowe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1916, to May 31 1916, that I last saw him alive on May 29 1916 and that death occured on the date stated above, at 4:20 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(Duration) ..... Yrs. ..... mos. 12 ds.
Contributory (Secondary) Senility
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. McKay M. D.
19 ..... (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Anthony — DATE OF BURIAL: June 2 1916

20. UNDERTAKER: Larkin & Sons Co — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9773

Registered No. 2273

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 654-S Main St.)

Registration District No. 84

Primary Registration District No. 2161

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Allan Meese

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb 29th 1916 (Month) (Day) (Year)

7. AGE: ... Yrs. 3 Mos. 10 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John H. Meese

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Edna L. Hargraves

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Meese

(Address) Pocatello Idaho

15. Filed June 9 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 9th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1916, to June 9 1916, that I last saw h... alive on June 9 1916, and that death occured on the date stated above, at 5A. M.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lukon Ida — DATE OF BURIAL: June 10 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Dr. Daly

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14774

Registered No. 477

1. PLACE OF DEATH.

Registration District No. 21

Primary Registration District No. 2161

County of Bannock

City of Tyhee (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Curtis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 19 (Day) 1916 (Year)

7. AGE: 3 hours (.....Yrs.....Mos.....ds.)

IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Tyhee

10. NAME OF FATHER N. R. Curtis

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Rose Price

13. BIRTHPLACE OF MOTHER (State or Country) Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N. R. Curtis

(Address) Pocatello R F D

15. Filed June 22, 1916 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1916, to June 19 1916, that I last saw him alive on June 19 1916, and that death occured on the date stated above, at 6 & 7/12 M.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) ..... Yrs. ..... mos. 3 hrs. ds.

Contributory (Secondary) Premature

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) J. M. Daly M. D.

6-16 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida — DATE OF BURIAL: June 22 1916

20. UNDERTAKER: Larkin & Sons — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH 84

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No.

Primary Registration District No. 2161

(No. .... St.)

File No. 9477

Registered No. 479

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Alexander

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Not Known (Month) 1 (Day) (Year)

7. AGE: 22 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer): Bank

9. BIRTHPLACE (State or Country): Provo Utah.

10. NAME OF FATHER: Frank D. Alexander.

11. BIRTHPLACE OF FATHER (State or Country): Iron County Utah.

12. MAIDEN NAME OF MOTHER: Sonoma Wilson

13. BIRTHPLACE OF MOTHER (State or Country): Provo Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank D. Alexander

(Address) Provo Utah.

15. Filed June 26, 1916 — O. P. Stone, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

by Jumping from toilet of Train #4 on Oregon Short Line about one and ½ miles East of Lava Hot Springs

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Knowles Coroner M. D.

June 26 1916 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Provo Utah — DATE OF BURIAL: June 28 1916

20. UNDERTAKER: Larkin + Sons — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

14776

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2161

(No. ....., ... St.)

File No. 9

Registered No. 478

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Knighton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): S (Single)

6. DATE OF BIRTH. Not Known

(Month) (Day) (Year)

7. AGE: 48 Yrs. 08 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. E. Johnson

(Address) Pocatello.

15. Filed June 23, 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 22 1916

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 191 . to June 22 1916, that I last saw h alive on June 22 1916, and that death occured on the date stated above, at 10½ A. M.

The CAUSE OF DEATH* was as follows:

Paralysis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Alleger M. D.

June 22 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake Utah — DATE OF BURIAL: June 25 1916

20. UNDERTAKER: Larkin & Sons — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

14777

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2161
File No. 9
Registered No. 476

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ..... , ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sigurd Wiker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word): Single

6. DATE OF BIRTH. Sept. (Month) 10 (Day) 1900 (Year)

7. AGE: 15 Yrs. 9 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Sven Wiker.

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Anna Forsbelg

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Sven Wiker
(Address) Pocatello, Idaho

15. Filed June 17, 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1916, to June 14 1916, that I last saw him alive on June 14 1916, and that death occured on the date stated above, at about 6:30 M.

The CAUSE OF DEATH* was as follows:
Pleurisy with effusion probably of tuberculous nature.
(Duration) Claimed When seen sick Yrs. 4 mos. ds.
Contributory (Secondary) Tuberculosis
(Duration Yrs. mos. ds.
(Signed) J. M. Hays M. D.
6-15- 1916 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho | DATE OF BURIAL: June 17 1916

20. UNDERTAKER: Larkin & Sons Co | ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 11778

Registered No. 1769

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 216

County of Bannock

City of Pocatello (No. Fortneuff Siding St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Tomas Kellow Sen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Exact date unknown 1855
June 1st (Month) (Day) 216 (Year)

7. AGE Near as known
61 Yrs. 6 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): Fort Hall mine

9. BIRTHPLACE (State or Country): Cornwell England

10. NAME OF FATHER: Tomas Kellow

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Marie Knowlen

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jane Kellow
(Address) Pocatello Idaho

15. Filed June 3 1916 O B Steel Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1st 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1916, to April 15 1916, that I last saw him alive on March 18 1916 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis.

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) A M. Newton M. D.

June 3 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. DATE OF BURIAL: June 3 1916

20. UNDERTAKER: Schumacher & Hall ADDRESS: City

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9 14779
Registered No. 478

1. PLACE OF DEATH.

County of Bannock
City of Pocatello
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 54
Primary Registration District No. 216
(No. Pocatello General Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jerome Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 4 (Day) 1895 (Year)

7. AGE: 21 Yrs. 2 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John M. Evans

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake, Utah.

12. MAIDEN NAME OF MOTHER: Isabell Burnett

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D H Evans
(Address) Lava Hot Springs

15. Filed June 1st 1916 E. E. Rowe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 th (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-29 1916, to 6-1- 1916, that I last saw h- alive on 6-1- 1916 and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Septic Meningitis

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Acute Otitis Media.

(Duration) Yrs. mos. 3 ds.

(Signed) J. P. Richards M. D.

6/2 1916 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arimo Idaho — DATE OF BURIAL: June 3 1916

20. UNDERTAKER: Schumacher & Hull — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161

File No. 9 14780
Registered No. 14780

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter Francis Brewster

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Use word.): Widower

6. DATE OF BIRTH.
May (Month) 17 (Day) 1847 (Year)

7. AGE
69 Yrs. 0 Mos. 17 ds.
IF LESS than 1 day how many ..hrs. or ..min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Ohio - Medina Co.

10. NAME OF FATHER: Norman Brewster.

11. BIRTHPLACE OF FATHER
(State or Country) Vermont.

12. MAIDEN NAME OF MOTHER: Nancy Phillips.

13. BIRTHPLACE OF MOTHER
(State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) San Pedro Cal.

15. Filed June 7, 1916
848 h. Arthur Lee
Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1916, to June 4th 1916, that I last saw him alive on June 4th 1916, and that death occured on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis - Uraemia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Enlarged Prostate - Cardio-vascular Renal disease
(Duration 2 or 3 yrs. ..... mos. ..... ds.

(Signed) H. A. Coates M. D.
June 6th 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho
DATE OF BURIAL: June 7 1916
20. UNDERTAKER: Larkin & Sons Co
ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14781

Registered No. 472.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alexander J Shursby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word): Widowed

6. DATE OF BIRTH. Not Known (Month) (Day) (Year)

7. AGE: about 60 years. ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Traveling

9. BIRTHPLACE (State or Country): Not Known

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W O Johnson

(Address) Pocatello

15. Filed June 8 1916

O B Feuby
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Francis H Poole M. D.

June 6 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lakeside Mich.	June 13 1916
20. UNDERTAKER	**ADDRESS**
Larkin & Downs	Pocatello.

Please see reverse side for instructions. Every question must be answered. Where the word "None" is the proper answer, it must be written. Do not use ditto marks. Be sure that the date of death is complete. Be sure that the statement of OCCUPATION is very important. See instructions on back.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9478?
Registered No. 474

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ..... St.)
Registration District No. 84
Primary Registration District No. 2161

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sylvia Spidell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH.
Dec. (Month) 15 (Day) 1883 (Year)

7. AGE
33 Yrs. 5 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)..... At Home

9. BIRTHPLACE
(State or Country) Red Rock Idaho

10. NAME OF FATHER: James F. Hunt

11. BIRTHPLACE OF FATHER
(State or Country) Utah.

12. MAIDEN NAME OF MOTHER: Artimacy Morton

13. BIRTHPLACE OF MOTHER
(State or Country) Provo Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Iza Spidell
(Address) Swan Lake, Ida

15.
Filed June 10th 1916
O B Steely
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1916, to June 9 1916, that I last saw h[illegible] alive on June 1916, and that death occured on the date stated above, at 4a M.

The CAUSE OF DEATH* was as follows:
Tuberculosis
Intestines

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
June 19 16 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Red Rock Idaho
DATE OF BURIAL: June 11 1916
20. UNDERTAKER: Larkin & Sons
ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 9783
Registered No. 275

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH.
Aug. (Month) 14 (Day) 1845 (Year)

7. AGE
71 Yrs. 9 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): Builder

9. BIRTHPLACE
(State or Country) Sweeden

10. NAME OF FATHER
Not Known

11. BIRTHPLACE OF FATHER
(State or Country) Not Known

12. MAIDEN NAME OF MOTHER
Not Known

13. BIRTHPLACE OF MOTHER
(State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Emma Stipp
(Address) Pocatello Idaho.

15.
Filed June 12 1916
O. F. Bliss
Local Registrar

SYMS - YORK CO., PTRS. & SORR. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1916, to June 10 1916, that I last saw h. alive on June 10 1916 and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(Duration) ..... Yrs. — mos. 4 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Howard M. D.
6/12 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida — DATE OF BURIAL: June 12. 1916

20. UNDERTAKER: Larkin & Sons — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SPACE RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 46

Primary Registration District No. 2123

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14784

Registered No. 4

1. PLACE OF DEATH.

County of Benewah.

City of Plummer.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Oscar. Braun

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 21st (Day) 1913 (Year)

7. AGE: Yrs. 11 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Baby.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kootenai Co. Idaho.

10. NAME OF FATHER Carl Frederich Braun

11. BIRTHPLACE OF FATHER (State or Country) Wittenberg, Germany.

12. MAIDEN NAME OF MOTHER Emma Truckenmuller.

13. BIRTHPLACE OF MOTHER (State or Country) Wittenberg, Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Carl Braun.
(Address) Plummer, Idaho.

15. Filed July 11 1916 — H. J. Jaeger. Local Registrar

SYMS - YORK CO., PTRS. & RDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8th 1916, to July 10th 1916, that I last saw him alive on July 10th 1916, and that death occured on the date stated above, at 7-a M.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis.

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. C. Harrington M.D.

July 1916 (Address) Plummer, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Plummer, Idaho. DATE OF BURIAL: July 12th 1916

20. UNDERTAKER: A. G. Jaeger. ADDRESS: Plummer,

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia — Registration District No. 167

City of Burley — Primary Registration District No. 2196

(No. ..... St.)

File No. 14785

Registered No. 129

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Jamieson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 8 (Day) 1916 (Year)

7. AGE: ~~0~~ Yrs. ~~0~~ Mos. 30 ds.

IF LESS than 1 day, how many ..... hrs. ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At home.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Cassia Co. Ida.

10. NAME OF FATHER Alex Jamieson.

11. BIRTHPLACE OF FATHER (State or Country) Wyoming

12. MAIDEN NAME OF MOTHER Mary E. Jones.

13. BIRTHPLACE OF MOTHER (State or Country) Davis Co. Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R D Jones
(Address) Burley Ida. R.F.D. # 3.

15. Filed June 8th 1916. Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) — 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1916, to May 22 1916, that I last saw him alive on May 22 1916, and that death occured on the date stated above, at — a M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) R. F. Stamm M. D.

19..... (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: June 7 1916

20. UNDERTAKER: L. B. Calloway ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14786

Registered No. 120

Registration District No. 117

Primary Registration District No. 2196

1. PLACE OF DEATH.

County of Cassia

City of Burley (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James W. Faltner.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. July (Month) 24 (Day) 1853. (Year)

7. AGE: 63 Yrs. 11 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana.

10. NAME OF FATHER Frank Faltner.

11. BIRTHPLACE OF FATHER (State or Country) Ky.

12. MAIDEN NAME OF MOTHER Rosa Matthews.

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lulu Baker Barclay
(Address) Burley Ida.

15. Filed June 29 1916. Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1916, to June 28th 1916, that I last saw h. alive on June 21st 1916, and that death occured on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

(Duration) Uncertain Yrs. mos. ds.

Contributory (Secondary) Chronic Bright's Disease

(Duration Uncertain yrs. mos. ds.

(Signed) J. C. Patterson M. D.

6-29 1916. (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Humboldt Neb. DATE OF BURIAL: July 2 1916

20. UNDERTAKER: J. Holloway. ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 14787
Registered No. ____

1. PLACE OF DEATH.
County of Latah
City of Briggs.
(No. ____ ____ St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank A. Fenton.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. July (Month) 24 (Day) 1851 (Year)
7. AGE: 64 Yrs. 11 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE New York State (State or Country)
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (State or Country)

Jno Heston Informant

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lanford Forbush
(Address) Bates Idaho

15.
Filed 6-30 1916 C. Cherrington Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/25 1916, to 6/27 1916, that I last saw him alive on 6/27 1916, and that death occured on the date stated above, at 3.0 M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
(Duration) ____ Yrs. 6 mos. ____ ds.
Contributory (Secondary) Arteriosclerosis.
(Duration 5 yrs. ____ mos. ____ ds.
(Signed) Ben F. Roseman M. D.
6/27 1916 (Address) Briggs. Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bates — DATE OF BURIAL: July 1 1916

20. UNDERTAKER: C. Cherrington — ADDRESS: Briggs

SVMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 14788
Registered No. .....

1. PLACE OF DEATH.
County of Lemhi
City of Briggs.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie Richmond Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
12 (Month) 10 (Day) 1846 (Year)

7. AGE
71 Yrs. 6 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Ogden City Utah

10. NAME OF FATHER: Henry S Nelson

11. BIRTHPLACE OF FATHER
(State or Country) ~~Council~~ Bluffs Iowa Council

12. MAIDEN NAME OF MOTHER: Mary Ellen McMillen

13. BIRTHPLACE OF MOTHER
(State or Country) Liverpool Eng.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry S Nelson
(Address) Briggs Idaho

15.
Filed 6-27 1916 C Herrington Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
6 (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/21, 1916, to 6/21, 1916, that I last saw h sin alive on 6/21, 1916, and that death occured on the date stated above, at 8:30 P M.

The CAUSE OF DEATH* was as follows:
Had Epileptic Convulsion, while fishing Sick, and fell in Stream and Asphyxiated.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Epilepsy.
(Duration 13 yrs. ..... mos. ..... ds.
(Signed) Ben F. Rosman M. D.
6/22 1916 (Address) Briggs Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: ~~Boise~~ Victor — DATE OF BURIAL: June 24 1916

20. UNDERTAKER: Aldermington — ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lisbon

City of Driggs

Registration District No. 77

Primary Registration District No. 2776

(No. ..... St.)

File No. 14789

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emelyan Jos. Olmstead

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Dec (Month) 8 (Day) 1879 (Year)

7. AGE: 36 Yrs. 5 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Proprietress of
(b) General nature of industry, business, or establishment in which employed (or employer): Hotel

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Benj. Peterson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Albertina Larsen

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H B Olmstead
(Address) Driggs Ida

15. Filed 6-3- 1916 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6. 3. 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/15- 1916, to 6/3 1916, that I last saw h alive on 6/3 1916, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Typhoid

(Duration) ..... Yrs. ..... mos. 19 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ben F. Freeman M. D.
6/14 1916 (Address) Driggs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elder Utah — DATE OF BURIAL: 6-7 1916

20. UNDERTAKER: Olmstead — ADDRESS: Driggs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
(No. ..... St.)

File No. 14790
Registered No. .....

1. PLACE OF DEATH.
County of Lemhi
City of Driggs
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie B. Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
5 (Month) 17 (Day) 1916 (Year)

7. AGE
..... Yrs. ..... Mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Driggs Idaho Lemhi County

10. NAME OF FATHER: Martin Luther Hill

11. BIRTHPLACE OF FATHER (State or Country): Brigham City Ut

12. MAIDEN NAME OF MOTHER: Martha Bufter

13. BIRTHPLACE OF MOTHER (State or Country): Wellsville Ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Martin L. Hill
(Address) Driggs Idaho

15. Filed 6. 17 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
6 (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/10 1916, to 6/17 1916, that I last saw her alive on 6/17 1916, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Pertussis.

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Benj F Roseman M. D.
6/17 1916 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Logan, Utah — DATE OF BURIAL: 6. 18 1916

20. UNDERTAKER: C. C. Kennedy — ADDRESS: Driggs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 14791
Registered No. 34

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. At Co Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joe Cook

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Feb (Month) 22 (Day) 1849 (Year)

7. AGE
67 Yrs. 4 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): U. S. State not Known

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. D. Frazee
(Address) Matron Co Home

15. Filed June 23 1916 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1915, to June 1916, that I last saw him alive on June 12 1916, and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. F. Carothers M. D.

6/22 1916 (Address) Moscow, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 3 yrs. 3 mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: June 23 1916

20. UNDERTAKER: Glen A. Gill — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH 61

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. 1011
File No. 14792
Registered No. 491
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cajsa Carlson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Dec (Month) 12 (Day) 1841 (Year)

7. AGE
74 Yrs. 5 Mos. 27 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): /

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Lundgren

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry Carlson
(Address) Moscow

15.
Filed June 11 1916
J. F. Race
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1916, to June 8 1916, that I last saw h[illegible] alive on June 5 1916, and that death occured on the date stated above, at 10:45 P M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
(Duration) 3 Yrs. 4 mos. — ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Wirt M. D.
June 10 1916 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: June 11 1916
20. UNDERTAKER: Glen O Gibb — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS & YORK CO., PTRS. & BOOKB. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14793

Registered No. 48

Registration District No. 61

Primary Registration District No. 1011

1. PLACE OF DEATH.

County of Latah

City of Moscow (No. 208 South Asbury St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary M. Witham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March 3rd 1849 (Month) (Day) (Year)

7. AGE: 67 Yrs. 3 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bolton, P of Quebec Canada

10. NAME OF FATHER: David Edgar Brill

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Abigail Drew

13. BIRTHPLACE OF MOTHER (State or Country): United States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. T. Witham

(Address) Moscow Idaho

15. Filed June 11 1916 D. F. Kane Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1916, to June 9 1916, that I last saw h alive on 1916, and that death occured on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:-

Acute Nephritis

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) J. N. Clarke M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: June 11 1916

20. UNDERTAKER: Glen O Grice — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 14794
Registered No. 42

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. 440, East 8th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander Anderson Campbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Oct (Month) 29 (Day) 1833 (Year)

7. AGE
82 Yrs. 7 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Moses Campbell

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Clark

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C A Campbell
(Address) Moscow

15.
Filed June 20 1916
D. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17, 1916, to June 17, 1916, that I last saw h[illegible] alive on June 17, 1916, and that death occured on the date stated above, at 1145 P. M.

The CAUSE OF DEATH* was as follows:
Paralysis, acute ascending

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. D. Fritzman M. D.
6/19 1916 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: June 20 1916

20. UNDERTAKER: Glen Grieb — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 14795
Registered No. 43

1. PLACE OF DEATH.
County of Latah
City of ..... (No. ....., St. ~~Main~~)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gertrude A ~~Robertson~~ Robertson
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Married

6. DATE OF BIRTH: Aug (Month) 8 (Day) 1888 (Year)

7. AGE: 27 yrs. 10 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Perry Heter

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A Robertson
(Address) Palouse Wash

15. Filed June 18 1916 L F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1916., to June 18 1916, that I last saw her alive on June 18 1916, and that death occurred on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:
Puerperal Septichemia
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Following an attempted abortion
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. L. Gutman M. D.
June 18 1916 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. /... days. In the State ..... yrs. ..... mos. /... days.
Where was disease contracted if not at place of death?
Former or usual residence Palouse, Wash.

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash | DATE OF BURIAL: June 19 1916

20. UNDERTAKER: E Anderson | ADDRESS: Palouse Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

61

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH:
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1011
(No. Gritman Hospital St.)

File No. 14796
Registered No. 44
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida Jane Boyd.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb. 11 (Month) 1 (Day) 67 (Year)

7. AGE: 49 yrs. 4 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John W Quigg

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Sarah Miller

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W M Boyd
(Address) Pullman Wash

15. Filed July 1 1916 J. F. Rea Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 29, (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11, 1916, to June 29, 1916, that I last saw her alive on June 29, 1916, and that death occurred on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:

Pericarditis ; Infectious

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.

6-29 1916 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2½ days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pullman Wn
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Glen Grice
ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 14797
Registered No. 473

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. 116 North Polk St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Caroline Alexander.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Nov. 14 (Month) 1 (Day) 1890 (Year)

7. AGE
25 Yrs. 7 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Michigan

10. NAME OF FATHER
Edgar Alexander.

11. BIRTHPLACE OF FATHER
(State or Country) Germany

12. MAIDEN NAME OF MOTHER
Katherine Knott.

13. BIRTHPLACE OF MOTHER
(State or Country) Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. J. Stewart.
(Address) Moscow Idaho.

15.
Filed June 23 191.....
L. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22nd 1916, to July - 3 - 191 5, that I last saw h[illegible] alive on July 191 6, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
three (Duration) 3 Yrs. 7 mos. ..... ds.
Contributory (Secondary) Tuberculosis
(Duration) 3 yrs. 6 mos. ..... ds.
(Signed) C. L. Patterson M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Snow Mountain Mich
DATE OF BURIAL: ..... 191.....

20. UNDERTAKER: Glen O Price
ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13 AMENDED ITEMS #15 & #19 7-29-97 MS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 14799
Registered No. 36

1. PLACE OF DEATH.
County of Madison
City of Burton
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Grasmick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. Feb. (Month) 24 (Day) 1857 (Year)
7. AGE: 59 Yrs. 4 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Russia
10. NAME OF FATHER: Geo. Grasmick
11. BIRTHPLACE OF FATHER (State or Country): Russia
12. MAIDEN NAME OF MOTHER: Mary Keller
13. BIRTHPLACE OF MOTHER (State or Country): Russia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Henry Grasmick
(Address) Burton
15. Filed JULY 8, 1916
G G Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 8 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 6 1916, to July 8 1916, that I last saw him alive on July 8 1916, and that death occured on the date stated above, at 10a M.
The CAUSE OF DEATH* was as follows: Fracture Base of Skull
(Duration) ..... Yrs. ..... mos. 3 hrs. ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Drs Parker & Young M. D.
1916 (Address) Teton Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Replevy — DATE OF BURIAL: JULY 10 1916
20. UNDERTAKER: John Phillips — ADDRESS: Replevy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

7/22/97

IDAHO DEPARTMENT OF HEALTH AND WELFARE
Center for Vital Statistics
and Health Policy

AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

State of Idaho
County of Ada } ss.

Certificate No. 16-14799
Date Filed _____

The undersigned does solemnly swear that certain facts on the certificate of DEATH
for HENRY GRASMICK (Name on Original Certificate) who DIED (Was Born, Died, etc.) on JULY 8, 1916 (Date of Event)
in BURTON, (MADISON), IDAHO (Place of Event) are erroneous or were omitted:

ITEMS TO BE CORRECTED	FROM	TO
#15 DATE FILED	JUNE 8, 1916	JULY 8, 1916
#19 DATE OF BURIAL	JUNE 10, 1916	JULY 10, 1916

Subscribed and sworn to before me this 29 day of July, 1997.
Notary Public, Teresa L. Clegerly
Residing at Boise, Idaho
My commission expires April 3, 2003
(Seal)

Thomas Williams
Signature of Applicant
1046 E. Shepherd St. Meridian ID
Street Address, City, State

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of _____
County of _____ } ss.

(Must be completed ___)
(Is not necessary ___)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this _____ day of _____, 19___.
Notary Public, _____
Residing at _____
My commission expires _____
(Seal)

_____
Supporting Signature

_____
Street Address, City, State

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 14800
Registered No. 29

1. PLACE OF DEATH.
County of Mad.
City of Redmere (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred L. Blackburn
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH
Feb. (Month) 7 (Day) 1849 (Year)

7. AGE
67 yrs. 3 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... merchant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Samuel Blackburn

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER ~~Sarah~~ Susannah Lamb

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas Blackburn
(Address) .....

15.
Filed 6-2 1916 G G Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
6 (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-30 1916, to 5-30 1916, that I last saw him alive on 5-30 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G G Espe M. D.
19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Redmere	6/2 1916
20. UNDERTAKER	ADDRESS
John Phillips	Redmere

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

[redacted]ERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2175
(No. ..... St.)

File No. 14801
Registered No. 30
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vera A. Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: ~~August~~ May (Month) 24 (Day) 1916 (Year)

7. AGE: 2 yrs. 2 mos. ~~2~~ ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Merkley R. Hill

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Luna Ellsworth

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. R. Hill
(Address) Rexburg

15. Filed 6-12 1916 G. E. Toops
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Syphilis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. E. Toops M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar City — DATE OF BURIAL: 6/13 1916

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-1[illegible]

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 14802
Registered No. 31

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amelia Kenison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Samoan
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Oct (Month) 14 (Day) 1901 (Year)
7. AGE: 14 Yrs. 8 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Africa, Samoa
10. NAME OF FATHER Alfred Kenison
11. BIRTHPLACE OF FATHER (State or Country) Africa
12. MAIDEN NAME OF MOTHER Judith
13. BIRTHPLACE OF MOTHER (State or Country) Africa
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alfred Kenison
(Address) Rexburg
15. Filed 6-19 1916 G L Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 18 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1916, to June 18 1916, that I last saw her alive on June 17 1916, and that death occured on the date stated above, at 8 P M.
The CAUSE OF DEATH* was as follows:
Tuberculosis, acute miliary
(Duration) Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) J O Mather M. D.
19.... (Address) Rexburg Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg	6/20 1916
20. UNDERTAKER John Phillips	ADDRESS Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 14803
Registered No. 32

1. PLACE OF DEATH.
County of Madison
City of Burton
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christena Stuart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. Sept (Month) 19 (Day) 1844 (Year)
7. AGE: 71 Yrs. 9 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Sweden
10. NAME OF FATHER: Erick Anderson
11. BIRTHPLACE OF FATHER (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) V. W. Anderson
(Address) Burton
15. Filed 6-25 1916 G. L. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 24 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 4-10 1916, to 6-24 1916, that I last saw her alive on 6-23 1916, and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. L. Espe M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL: 6/26 1916
20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 14804
Registered No. 33

1. PLACE OF DEATH.
County of Madison
City of Burton
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ross E. Heileson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov. (Month) 19 (Day) 1914 (Year)

7. AGE: 1 Yrs. 7 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Burton Ida

10. NAME OF FATHER N. E. Heileson

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Isabella D. Forsyth

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) N. E. Heileson
(Address) Burton

15. Filed 6-26 1916 G. L. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Head Crushed by wagon
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) G. L. Espe M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL: 6/27 1916

20. UNDERTAKER: John Phillips — ADDRESS: Replevin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14805
Registered No. 34

1. PLACE OF DEATH.

County of Wood.
City of Rex.
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

2. FULL NAME Charles H. Shanks

(If death occurred in a hospital, institution or camp, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan. (Month) 15 (Day) 1915 (Year)

7. AGE: 1 Yrs. 5 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Charles H. Shanks

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Edna Brenner

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles H. Shanks
(Address) Rexburg

15. Filed 6-27 1916
G. L. Esplin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h— alive on — 191...,
and that death occured on the date stated above, at 20 M.

The CAUSE OF DEATH* was as follows:
Drowning

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Joseph Wacker M. D.
19..... (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL, OR REMOVAL: Rexburg — DATE OF BURIAL: 6/29 1916

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14806
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Paris
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wilford Lewis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Single

6. DATE OF BIRTH
July (Month) 4 (Day) 1916 (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 5 .... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) E Paris Idaho

10. NAME OF FATHER Ezra J. Lewis

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Drucilla Passey

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Lou Lewis
(Address) Paris Idaho

15.
Filed ..... 191...
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1916, to July 4 1916, that I last saw him alive on July 4 1916, and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas E Hoffman M. D.
7/5 1916 (Address) Paris Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris Ida. DATE OF BURIAL: 7/5 1916

20. UNDERTAKER: M Undertaker ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14807

Registered No.

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

County of Bear Lake

City of Bloomington (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Thompson Patterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH: March 24 1874 (Month) (Day) (Year)

7. AGE: 42 yrs. 3 mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer and Mechanic
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bloomington, Idaho

10. NAME OF FATHER: Edward M, Patterson,

11. BIRTHPLACE OF FATHER (State or Country): England,

12. MAIDEN NAME OF MOTHER: Mary Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J.P.Patterson
(Address) Bloomington, Idaho.

15.
Filed ..... 191....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) Third (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1916 to July 3 1916, that I last saw h[illegible] alive on July 2 1916, and that death occurred on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Lungs.

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) Tuberculosis

(Duration) 10 yrs. — mos. — ds.

(Signed) R Sutton M. D.

July 10 16 (Address) Paris Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bloomington Idaho — DATE OF BURIAL: July 5 1916

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 126

Primary Registration District No. 2204

File No. 14808

County of Kootenai

City of Harrison (No. ....., ... St.)

Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosa Damiano

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	widow

6. DATE OF BIRTH

apr. (Month) 5 (Day) 1836 (Year)

7. AGE

80 yrs. 7 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER Joseph Procopia

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER ~~Beatta~~ Rosetta and Maria anna maria Rosetta

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Damiano

(Address) Harrison Ida

15.

Filed July 6 1916 R. S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1916, to June 30 1916, that I last saw her alive on June 29 1916, and that death occurred on the date stated above, at 5:00 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy (Hemorrhage) due to Senility

(Duration) — yrs. — mos. 7 ds.

Contributory (Secondary) atheroma

(Duration) — yrs. — mos. — ds.

(Signed) J. W. Didier M. D.

June 30 1916 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Harrison Ida	6-3 1916
20. UNDERTAKER	**ADDRESS**
E. W. Wheeler	Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Weipa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 14809
Registered No. 28
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Becka Fiddler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
May (Month) ..... (Day) 1858 (Year)

7. AGE
61 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Missouri

10. NAME OF FATHER
Peter Cook

11. BIRTHPLACE OF FATHER
(State or Country) Kent

12. MAIDEN NAME OF MOTHER
James.

13. BIRTHPLACE OF MOTHER
(State or Country) 2

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Fiddler
(Address) Weipa Idaho

15.
Filed July 1 1916 J M Bailey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191..., to ✓ 1916, that I last saw h ✓ alive on ✓ 1916, and that death occurred on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:
Unknown
No Medical attendence

7 (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
2 (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) J. M. Bailey M. D.
June 1 1916 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Weipa	June 2 1916

20. UNDERTAKER	ADDRESS
W. E. Stoddard	Giffnot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 20
Primary Registration District No. 3168
File No. 14810
Registered No. 29

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur Broberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. (Month) (Day) 1884. (Year)

7. AGE: 32 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Brakeman.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ?
10. NAME OF FATHER: ?
11. BIRTHPLACE OF FATHER (State or Country): ?
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Williams
(Address) Orofino. Idaho

15. Filed Mrs Broberg 191 Lewiston Jan 7
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7. 1916. to June 3. 1916.
that I last saw him alive on June 3. 1916.
and that death occured on the date stated above, at 7. P. M.

The CAUSE OF DEATH* was as follows:
General Paresis

(Duration) Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John Williams M. D.
June 3. 1916. (Address) Orofino. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 88. days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Lewiston. Idaho.
Former or usual residence Lewiston. Idaho.

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: June 5 1916

20. UNDERTAKER: H. E. Stoddard — ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 14811
Registered No. 30
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melvin H. Hardin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Baby

6. DATE OF BIRTH
(Month) June (Day) 23 (Year) 1916

7. AGE
yrs. 1 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Baby
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER W. G. Hardin

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Nancy Carson

13. BIRTHPLACE OF MOTHER (State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. G. Hardin
(Address) Orofino

15.
Filed July 1 1916 J. M. Geary Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8 1916 to June 9 1916
that I last saw him alive on June 9 1916
and that death occurred on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows:
Acute strangulation of bowel.

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Male premature child
(Duration) 1 hr. yrs. ..... mos. ..... ds.

(Signed) E. M. Horsewell M. D.
June 9 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida — DATE OF BURIAL: June 10 1916

20. UNDERTAKER: H. E. Stoddard — ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 90

Primary Registration District No. 7168

File No. 14812

County of Clearwater

City of Orofino (No. ....., ... St.)

Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hester Shubburn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 24 (Day) 1877 (Year)

7. AGE: 38 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Neb

10. NAME OF FATHER: Geo Cattel

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Cattel

13. BIRTHPLACE OF MOTHER (State or Country): 2

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. W. Schulhorn
(Address) Orofino Ida

15. Filed July 1 1916 J. M. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1916, to June 13 1916, that I last saw h[illegible] alive on June 13 1916, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) ..... yrs. 1 mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Young M. D.

June 13 1916 (Address) Orofino, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida — DATE OF BURIAL: June 15 1916

20. UNDERTAKER: W. E. Stoddard — ADDRESS: Gifford

GYMS - YORK CO., PTRS. & SONS. 19760

FORM V. S. No. 6 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14813
Registered No. 33

1. PLACE OF DEATH.
County of Clearwater
City of Orofino.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ..... St.)

2. FULL NAME Henry Bohle. N.V. Sanitarium.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 19 (Day) 1916. (Year)

7. AGE: 61 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Coal miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Germany.

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Timmens
(Address) Orofino. Idaho.

15. Filed July 1 1916
J. M. Daisley
Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13. 1914, to June 19. 1916., that I last saw him alive on June 18 1916., and that death occured on the date stated above, at 7. A. M.

The CAUSE OF DEATH* was as follows:
Epilepsy

(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity

(Duration) 2 yrs. ..... mos. ..... ds.
(Signed) John Timmens M. D.
June 19 1916. (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs 18 mos 15 days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? ?
Former or usual residence Idaho. Bonner Co

19. PLACE OF BURIAL OR REMOVAL: N.V. Sanitarium Cemetery. DATE OF BURIAL: June 21. 1916.
20. UNDERTAKER: P. M. Johnson ADDRESS: Orofino Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14814
Registered No. 33

1. PLACE OF DEATH.
County of Clearwater
City of Ahsahka (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 7168

2. FULL NAME Emma Gould

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 21 (Day) 1 (Year) 1916

7. AGE: ..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Owen Gould

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Helen Corbett Hoyt

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Owen Gould
(Address) Ahsahka Ida

15. Filed July 1 1916 J M Tawney Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21 1916, to June 24 1916, that I last saw him alive on June 24 1916, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Cerebral Tumor

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Tawney M. D.
June 24 1916 (Address) Orofino, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ahsahka — DATE OF BURIAL: June 26 1916

20. UNDERTAKER: W E. Stoddard — ADDRESS: Gifford

GYMS-YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 14815
Registered No. 34

1. PLACE OF DEATH.
County of Clearwater
City of Orofino.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME O.D. Wise N.I. Sanatarium

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1868 (Year)

7. AGE: 48 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Johnwilliams
(Address) Orofino. Idaho.

15. Filed July 1 1916 J.M. Tainter Local Registrar

STAR-TRIBUNE CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29. 1914. to June 28 1916., that I last saw him alive on June 27 1916., and that death occured on the date stated above, at 8:15 A.M.

The CAUSE OF DEATH* was as follows:
Epilepsy
..... (Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
..... (Duration 2 yrs. ..... mos. ..... ds.
(Signed) Johnwilliams M. D.
June 28 1916. (Address) Orofino. Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 2 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Idaho Co. Idaho
Former or usual residence Idaho.

19. PLACE OF BURIAL OR REMOVAL: N.I. Sanatarium Cmetery — DATE OF BURIAL: June 30 1916

20. UNDERTAKER: O.M. Johnson — ADDRESS: Orofino Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 14816
Registered No. 35

1. PLACE OF DEATH.
County of Clearwater
City of Orofino.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Leopold.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1849. (Year)

7. AGE
67 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Penn.

10. NAME OF FATHER
?

11. BIRTHPLACE OF FATHER
(State or Country)
?

12. MAIDEN NAME OF MOTHER
?

13. BIRTHPLACE OF MOTHER
(State or Country)
?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Simens
(Address) Orofino. Idaho.

15.
Filed July 1 1916
J. M. Tinsley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 29 (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1910, to June 29. 1916., that I last saw h im alive on June 29 1916, and that death occured on the date stated above, at 12.30 P M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis

..... (Duration) 6 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity.
..... (Duration) 19 yrs. ..... mos. ..... ds.
(Signed) John Simens M. D.
June 29 1916. (Address) Orofino

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. 6 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Latah Co. Idaho.
Former or usual residence Idaho.

19. PLACE OF BURIAL OR REMOVAL
N. I. Sanitarium Cemetery
DATE OF BURIAL June 30 1916.

20. UNDERTAKER
P. M. Johnson.
ADDRESS Orofino. Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14817

Registered No. 61

Registration District No. 9c

Primary Registration District No. 909

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston (No. St. Joseph Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elva Peak

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 11 (Day) 1 (Year)

7. AGE: 23 Yrs. 5 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: H L Dingman

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Gertrude Lyle

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H L Dingman

(Address) Ahsahka Idaho

15. Filed 7-10- 1916 L J Parkin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 3rd 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 191..., to 3rd 1916, that I last saw her alive on June 3rd 1916, and that death occured on the date stated above, at 7-0 M.

The CAUSE OF DEATH* was as follows:

Puerperal Sepsis

following abortion

for Extra Uterine Pregnancy

(Duration) Yrs. 4 mos. ds.

Contributory (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) H. Kerrigan M. D.

19... (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ahsahka — DATE OF BURIAL ....191...

20. UNDERTAKER: Lassar — ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9C
Primary Registration District No. 1009
File No. 14819
Registered No. 33

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. ..... Hospital ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Goldner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH. Feb (Month) 18 (Day) 1867 (Year)

7. AGE: 49 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Nick Eicher

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER — Gallas

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George W Goldner
(Address) .....

15. Filed 7-10 1916 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
6 (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 1915, to June 20 1916, that I last saw h[illegible] alive on June 20 1916, and that death occured on the date stated above, at [illegible] P M.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation

(Duration) 12 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Not Known
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John N Alley M. D.
6-20 1916 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: June 22 1916

20. UNDERTAKER: C J Vaughan — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9C
Primary Registration District No. 1009
File No. 14820
Registered No. 54

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. St. Mary's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Addie L Stevens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec (Month) 8 (Day) 1876 (Year)

7. AGE: 39 Yrs. 6 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: D B Randall

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Arabella Cuykendall

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Otonoco L Randall Stephens
(Address) .....

15. Filed 7-10- 1916
L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1916, to June 24 1916, that I last saw her alive on June 24 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Decomposition of Appendicitis

(Duration) - Yrs. - mos. 8 ds.
Contributory (Secondary) General peritonitis
(Duration - yrs. - mos. 2 ds.

(Signed) L. J. Perkins M. D.
6/24 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida
DATE OF BURIAL: June 1916

20. UNDERTAKER: C. J. Vasan
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

EVANS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
(No. ....., ... St.)

File No. 14821
Registered No. 55

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H Sebastian

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 31 (Day) 1851 (Year)

7. AGE: 64 Yrs. 5 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missoure

10. NAME OF FATHER: Dan Sebastian

11. BIRTHPLACE OF FATHER (State or Country): (Dont Know)

12. MAIDEN NAME OF MOTHER: (Dont Know)

13. BIRTHPLACE OF MOTHER (State or Country): (Don Know)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs H H Sebastian
(Address) Clarkston Wash

15. Filed 7-10- 1916 L J Perkins Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Wed June 28 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1916, to June 28 1916, that I last saw him alive on June 27 1916, and that death occured on the date stated above, at 4P. M.

The CAUSE OF DEATH* was as follows:
Peptic ulcer with perforation
(Operation performed)
Duration of ulcer 2 yrs or more
(Duration) Yrs. mos. ds.
Contributory (Secondary) Perforation 4 days
(Duration yrs. mos. ds.
(Signed) Paul D Johnson M. D.
June 28 1916 (Address) Clarkston Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs..mos. 3 days. In the State ..yrs..mos. 3 days
Where was disease contracted if not at place of death? Clarkston Wash.
Former or usual residence Clarkston, Wash.

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash — DATE OF BURIAL: 6/30 1916

20. UNDERTAKER: H R Merchant — ADDRESS: Clarkston Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 95

Primary Registration District No. 1009

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14822

Registered No. 22

1. PLACE OF DEATH.

County of Nez Perce

City of

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Syntha Ann Cole

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 30 (Day) 1850 (Year)

7. AGE: 66 Yrs. 5 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: S. Bridgeman

11. BIRTHPLACE OF FATHER (State or Country): Unr

12. MAIDEN NAME OF MOTHER: Malinda J Hacker

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jerome Cole

(Address) Spalding

15. Filed 7-10- 1916

L J Perkins
Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Presume-disease of heart, dead when I called. I only made one visit.

(Duration) 1/2 Yrs. — mos. 2 hrs ds.

Contributory (Secondary) —

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L J Perkins M. D.

6/30 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: July 1 1916

20. UNDERTAKER: [signature] — ADDRESS: Lewiston

FORM V. S. No. 6-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 21

Primary Registration District No. 2022

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14823

Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Rathdrum

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frederick A Stiffler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) (Day) 1855 (Year)

7. AGE: 60 Yrs. 9 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bedford Co Pa

10. NAME OF FATHER: Joseph Stiffler

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W H Stiffler

(Address) Rathdrum

15. Filed 6/30 1916 Robert H Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 20

March (Month) July (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Consumption

(Duration) about 3 weeks Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) No Physician M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kelcham — DATE OF BURIAL: Mch 16 1916

20. UNDERTAKER: R D Harris — ADDRESS: Harrison

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STNRS. 24658

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
(No. ....., ... St.)

File No. 14824
Registered No. 14

1. PLACE OF DEATH.
County of Blaine
City of Bellevue

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James A Wrencher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Wht	Married

6. DATE OF BIRTH. Nov 25 1837
(Month) (Day) (Year)

7. AGE 78 Yrs. 3 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Ambrose Wrencher

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Sarah Williams

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Jas A Wrencher
(Address) Bellevue Idaho

15. Filed June 30 1916 Robert H. Wright
Local Registrar

BYRNS—YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov 17 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1916, to Nov 17 1916,
that I last saw him alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cancer of stomach and Liver

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) O J Allen M. D.
19.... (Address) Bellevue Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bellevue	Nov 19 1916
20. UNDERTAKER	**ADDRESS**
R D Harris	Hailey Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2074
(No. ....., ... St.)

File No. 14825
Registered No. 75

1. PLACE OF DEATH.
County of Blaine
City of Hailey
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Esther Fleming

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Wht—
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Feb (Month) 15 (Day) 1840 (Year)

7. AGE: 76 Yrs. 1 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... H W.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Saul Johnson

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs John Seymour
(Address) Hailey Ida

15. Filed June 30 1916 Robert H. Wright Local Registrar

BYRNE-YORK CO., PTRS. & BKBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1915, to Mch 20 1916, that I last saw h[illegible] alive on Mch 20 1916, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Robert H. Wright M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida
DATE OF BURIAL: 3/22 1916

20. UNDERTAKER: R. L. Harris
ADDRESS: Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2034
(No. ....., ... St.)

File No. 14826
Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Blaine
City of Hailey
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank E. Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Dec (Month) 1 (Day) 1856 (Year)

7. AGE: 79 Yrs. 5 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. W. Benson
(Address) Hailey Idaho

15. Filed June 30 1916 Robert H. Wright Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1916, to May 10 1916, that I last saw him alive on May 10 1916, and that death occured on the date stated above, at 3 05 P.M.

The CAUSE OF DEATH* was as follows:
Rocky Mountain Tick Fever
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) R. W. Hailey M. D.
19..... (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida — DATE OF BURIAL: May 17 1916

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey Ida

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14827

Registered No. 17

1. PLACE OF DEATH.

County of Blaine

City of Muldoon

Registration District No. 21

Primary Registration District No. 2072

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth A. Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept 29 (Month) (Day) 1900 (Year)

7. AGE: 15 Yrs. 8 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wasley -

10. NAME OF FATHER: Andrew Harris

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mina McMunnel

13. BIRTHPLACE OF MOTHER (State or Country): Neb -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E A Harris

(Address) Muldoon Idaho.

15. Filed June 30 1916 Robert H Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 2 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31st 1916, to June 2 1916, that I last saw her alive on June 2 1916, and that death occured on the date stated above, at 2 30 M.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobular -

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E W Kleinman M. D.

19..... (Address) Hailey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wasley — DATE OF BURIAL: June 4 1916

20. UNDERTAKER: R N Harris — ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & PUBS. 94658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21

County of Blaine

Primary Registration District No. 2075

File No. 14828

City of Trail Creek near Carey (No. ....., ... St.)

Registered No. 78

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Shaffer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug 9 (Month) ..... (Day) 1884 (Year)

7. AGE: 31 Yrs. 9 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) /

10. NAME OF FATHER /

11. BIRTHPLACE OF FATHER (State or Country) /

12. MAIDEN NAME OF MOTHER /

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Shaffer

(Address) Trail Creek, Ida.

15. Filed June 30 1916 Robert H Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Sept.~~ May 28 1916, to June 2 1916, that I last saw him alive on June 1 1916, and that death occured on the date stated above, at 2:15 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. G. Burch M. D.

6/30 1916 (Address) Bellevue Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bellevue — DATE OF BURIAL: June 4 1916

20. UNDERTAKER: R D Harris — ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
(No. ....., ... St.)

File No. 14829
Registered No. 19

1. PLACE OF DEATH.
County of Payne
City of Lechuuss
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jesse Hughes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Nov (Month) 24 (Day) 1835 (Year)
7. AGE: 80 Yrs. ..... Mos. 6 ds. 3
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Stock
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Wisc
10. NAME OF FATHER: Andy Hughes
11. BIRTHPLACE OF FATHER (State or Country):
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nancy Hughes
(Address) Lechuuss
15. Filed July 9 1916 Robert X Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 31 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 16 1916, to May 30 1916, that I last saw him alive on May 30 1916, and that death occured on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows:
Senility
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) J J Plummer M. D.
19..... (Address) Payne Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lechuuss — DATE OF BURIAL: 6/2 1916
20. UNDERTAKER: W H Reynolds — Latin ADDRESS: Lechuuss

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STUBS - STUB CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Bellevue
(No. ....., ... St.)

Registration District No. 21
Primary Registration District No. 2022

File No. 14830
Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Campbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR, DIVORCED. (Write the word.): married.

6. DATE OF BIRTH. Sept. (Month) 24 (Day) 1849 (Year)

7. AGE: 66 Yrs. 9 Mos. ... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nova Scotia.

10. NAME OF FATHER: Gw Campbell.

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Helen C. Gunn.

13. BIRTHPLACE OF MOTHER (State or Country): Nova Scotia.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Helen J. Campbell
(Address) Bailey

15. Filed July 9 191 6 Robert H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1915 to June 25 1916, that I last saw her alive on June 25 1916, and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) A. G. Burnett M. D.
6/26 1916 (Address) Bellevue Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellevue Ida — DATE OF BURIAL: 6/28 1916

20. UNDERTAKER: R. L. Harris — ADDRESS: Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 21

Primary Registration District No. 2022

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14831

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Blaine

City of Hailey

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katherine Edwardt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. April (Month) 26 (Day) 1846 (Year)

7. AGE: 70 Yrs. 1 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Germany.

10. NAME OF FATHER Jacob Kalfleisch.

11. BIRTHPLACE OF FATHER (State or Country) Germany.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carl H. Neysius

(Address) Hailey Ida.

15. Filed July 9 1916 Robert H Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21 1916, to June 24 1916, that I last saw her alive on June 24 1916, and that death occured on the date stated above, at 6-P M.

The CAUSE OF DEATH* was as follows: Rocky Mountain tick fever

..... (Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Rauf M. D.

19..... (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Watertown Wis

DATE OF BURIAL: Shipped June 26 1916

20. UNDERTAKER: Ralph D Harris

ADDRESS: Hailey, Idaho

SYMS-YORK CO., PTRS. & STNRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14832
Registered No.

1. PLACE OF DEATH.
County of Jefferson
City of Gorfield
If death occurs away from usual residence, *give facts called for under special information.*

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Sorensen

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.): Married

6. DATE OF BIRTH: May (Month) 22 (Day) 1916 (Year)

7. AGE: 0 yrs. 0 mos. 0 ds.
IF LESS than 1 day how many ..11.. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Charles A Sorensen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lavina Sorensen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Chas A Sorensen
(Address): Gorfield Ida Rigby Ida #1

15. Filed May 27 1916 Ray S Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1916, to May 27 1916, that I last saw h.. alive on May 27 1916, and that death occurred on the date stated above, at 3 39 M.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis
Gastritis 11 hrs.
(Duration) — yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Ray S Fisher M. D.
19.. (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grant Idaho — DATE OF BURIAL: May 29 1916

20. UNDERTAKER: None — ADDRESS: —

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14833

Registered No.

1. PLACE OF DEATH.
County of Jefferson
City of St. Rexie (No. 2 D, St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.

2. FULL NAME LeRay Smith

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married

6. DATE OF BIRTH: Oct (Month) 9 (Day) 1889 (Year)

7. AGE: 26 yrs. 9 mos. 21 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Benj. Smith

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Margur Smith

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Moore
(Address) Rexie Idaho

15. Filed July 13 1916 Ray Tibbs Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1916, to June 23 1916, that I last saw h[illegible] alive on June 23 1916, and that death occurred on the date stated above, at 6 30 A.M.

The CAUSE OF DEATH* was as follows:

Rocky Mountain Spotted Fever
(Duration) yrs. mos. 16 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A. M. Gilmer M. D.
7/1 1916 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs. 6 mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelton Idaho
DATE OF BURIAL: July 3 1916

20. UNDERTAKER: Ine
ADDRESS: —

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14834
Registered No.

1. PLACE OF DEATH.
County of Jefferson
City of Rigby Ida
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Henry Havens Rebecker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Apr 1st 1841 (Month) (Day) (Year)

7. AGE: 75 yrs. 2 mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Jersey

10. NAME OF FATHER: Hendy Havens

11. BIRTHPLACE OF FATHER (State or Country): [redacted]

12. MAIDEN NAME OF MOTHER: Mary Vanwagoner

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Rebecker
(Address): Rigby R D 2 Ida

15. Filed June 16 1916 Ray Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 15th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1916, to June 15 1916, that I last saw him alive on about May 15th 1916, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) one yrs. 1 mos. ds.

Contributory (Secondary): Cardio Renal

(Duration) one yrs. mos. ds.

(Signed) H. A. Anderson M. D.
June 19 16 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby Ida — DATE OF BURIAL: June 16 1916

20. UNDERTAKER: None — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

RIGHT OF REVISION RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19750

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 14836
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of ( ) (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald T. Tooley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 12 (Day) 1916 (Year)

7. AGE: ~ Yrs. ~ Mos. ~ ds.
IF LESS than 1 day how many.. 2 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. T. Tooley

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Sarah Dayley

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. T. Tooley
(Address) Burley Idaho

15. Filed 6-13 1916
John R. Corbett
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1916, to June 12 1916, that I last saw him alive on June 12 1916, and that death occured on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Premature birth.

(Duration) ~ Yrs. ~ mos. ~ ds.

Contributory (Secondary) ~

(Duration) ~ yrs. ~ mos. ~ ds.

(Signed) John R. Morgan M. D.
6/12/1916 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ~ yrs. ~ mos. ~ days. In the State ~ yrs. ~ mos. ~ days
Where was disease contracted if not at place of death? ~
Former or usual residence ~

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho
DATE OF BURIAL: June 15 1916

20. UNDERTAKER: Grossman and Emery
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 14837
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME No Name {Williams}

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May 29- 1916 (Month) (Day) (Year)

7. AGE ..... Yrs. 3 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Twin Falls.

10. NAME OF FATHER J. T. Williams

11. BIRTHPLACE OF FATHER (State or Country) Oklahoma

12. MAIDEN NAME OF MOTHER Mary Manning

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. T. Williams
(Address) Twin Falls Ida

15. Filed 6-1 1916 J. Crozier Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1st 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/29 1916, to 6/1 1916, that I last saw him alive on 5/31 1916, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Meningeal Hemorrhage

(Duration) ..... Yrs. ..... mos. 2½ ds.

Contributory (Secondary) .....
(Duration ..... yrs ..... mos. ..... ds.

(Signed) W. F. Tibbs M. D.
6/1/1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~ Twin Falls — DATE OF BURIAL 6-1 1916

20. UNDERTAKER E. Crosby — ADDRESS Twin Falls

...ORM, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
...information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
...CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
...of OCCUPATION is very important. See instructions on back of certificate.

...S - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14838

Registered No. .....

Registration District No. 37

Primary Registration District No. 1085

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Twin Falls

City of ( ) ( )

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie adell Hollister

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 18 (Day) 1916 (Year)

7. AGE: ....Yrs. ....Mos. 2 ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work....

(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Homer G Hollister

11. BIRTHPLACE OF FATHER (State or Country) Kans.

12. MAIDEN NAME OF MOTHER Nora Bell Hennigan

13. BIRTHPLACE OF MOTHER (State or Country) Kans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H G Hollister

(Address) Homer G Hollister

15. Filed June 20 1916 John S Boughton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1916, to June 19 1916, that I last saw h er alive on 6-19- 1916, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Twin babe

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

....(Duration ....yrs. ....mos. ....ds.

(Signed) John R Morgan M. D.

6-19 1916 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: June 20 1916

20. UNDERTAKER: Swanson & Eccles — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14839
Registered No. .....

Registration District No. 37
Primary Registration District No. 2085

1. PLACE OF DEATH.
County of Twin Falls
City of Kimberly
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Van Staley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Jan (Month) 9 (Day) 1898 (Year)
7. AGE: 18 Yrs. 3 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Public School
(b) General nature of industry, business, or establishment in which employed (or employer): Pupil
9. BIRTHPLACE (State or Country): Utah
10. NAME OF FATHER: M. F. Staley
11. BIRTHPLACE OF FATHER (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Bethia Powell
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jay Staley
(Address) Kimberly, Ida.
15.
Filed 5-3 1916 John H. Coryell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
5 (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 9, 1916, to May 3, 1916, that I last saw him alive on May 3, 1916, and that death occured on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
Probably (Duration) Several Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) W. F. [illegible] M. D.
5/3 1916 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls, Ida
DATE OF BURIAL: 5-3 1916
20. UNDERTAKER: None
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 14840
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls.
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles E Hitchcock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan 30 (Month) (Day) 1861 (Year)

7. AGE: 55 Yrs. 4 Mos. 13 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Charles Hitchcock

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Lora Eastman

13. BIRTHPLACE OF MOTHER (State or Country) New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ella Hitchcock
(Address) Twin Falls R.F.D.

15. Filed 5-14 1916 J Wheeler Brigham Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 - 13 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Summer 1911, to 5-13 1916, that I last saw h sim alive on 5-13 1916, and that death occured on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 1/2 ds.
Contributory (Secondary) arterio sclerosis
(Duration several yrs. ..... mos. ..... ds.
(Signed) Chas. R. Scott M. D.
5-13 1916 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shell Rock Iowa
DATE OF BURIAL 191

20. UNDERTAKER: C. J. Creasey
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24655

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 14841
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls.
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jonas M. Jones.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Oct (Month) 2 (Day) 1836 (Year)

7. AGE: 79 Yrs. 7 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Vincent

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Charlott Ghent

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. Ira Jones.
(Address) J. Topeka Kansas

15. Filed May 28 1916 John D. Coughlin Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1916, to May 23 1916, that I last saw h.... alive on May 23 1916, and that death occured on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Wilson M. D.
May 29 1916 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Menlo. Kans. | DATE OF BURIAL ..... 191...

20. UNDERTAKER: Grossman & Ewell | ADDRESS: Twin Falls Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14842

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of .....

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 2085

2. FULL NAME L. L. Welch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Jan 13th 1878
(Month) (Day) (Year)

7. AGE: 38 Yrs. 4 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bellefontaine Iowa

10. NAME OF FATHER: Welch

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Elizabeth Holly

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edna B. Lane
(Address) Douglas Wyo

15. Filed 6-6 1916 J. H. Coyle Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 4th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1916, to June 7 1916, that I last saw him alive on June 4 1916, and that death occured on the date stated above, at 1 m. M.

The CAUSE OF DEATH* was as follows:
Wernicke Encephalopathy

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo Berry M. D.

June 7 1916 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 6-7 1916

20. UNDERTAKER: C. J. Crosby — ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31
Primary Registration District No. 1085
File No. 14843
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Irwin Grant Alger.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. May 14 (Month) (Day) 1867 (Year)

7. AGE: 48 Yrs. 11 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER: Grant Alger

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Alger, Son "
(Address) Twin Falls R.F.D. #3

15.
Filed 5-8 1916
J. E. Coughlan
Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 6 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-30 1916, to 5-6 1916, that I last saw him alive on 5-6 1916, and that death occured on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:
Uri & Cyo Cholecystitis

(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) Duodenal Adhesions with secondary Acute dilation of Stomach
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John R. Morgan M. D.
5-6 1916 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: T F
DATE OF BURIAL: 5-8 1916

20. UNDERTAKER: Crosby
ADDRESS: T. F.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 14844
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mable Luella Stradley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH. Sept 18th 1903 (Month) (Day) (Year)

7. AGE: 12 Yrs. 7 Mos. 23 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: W. F. Stradley

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Emma E. Cooper

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. F. Stradley
(Address) R.F.D. #1 Filer

15. Filed May 13 1916 Jolad F. Coughlen Local Registrar

SYMS - YORK CO., PTRS. & BKRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 1916, to May 11 1916, that I last saw her alive on May 11 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Mastoid abscess

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Influenza and otitis media
(Duration) ..... yrs. 1 mos. 14 ds.
(Signed) Chas. Wilhelm M. D.
5/12 1916. (Address) Burke Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Removal

19. PLACE OF BURIAL OR REMOVAL: Filer Idaho
DATE OF BURIAL: 5-14 1916

20. UNDERTAKER: E J Crosby
ADDRESS: T Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 7085
(No. .... St.)

File No. 14815
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank C Robinson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
May (Month) 9 (Day) 1883 (Year)

7. AGE
33 Yrs. 0 Mos. 11 ds.
IF LESS than 1 day how many .....hrs. or .....min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Civil Engineer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Kansas.

10. NAME OF FATHER: F C Robinson

11. BIRTHPLACE OF FATHER
(State or Country) Vermont

12. MAIDEN NAME OF MOTHER: Susan V. Landon

13. BIRTHPLACE OF MOTHER
(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harold Prentice,
(Address) Clifton, Kans.

15.
Filed May 22 1916 John F Eagleson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1916, to May 20 1916, that I last saw h[illegible] alive on May 20 1916, and that death occured on the date stated above, at 7:30P M.

The CAUSE OF DEATH* was as follows:
General peritonitis from typhoid perforation

(Duration) 4 hrs. Yrs. ..... mos. ..... ds.
Contributory (Secondary) Typhoid fever
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) John F Eagleson M. D.
5/22 1916 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Washington, Kans.

19. PLACE OF BURIAL OR REMOVAL: Washington Kansas. DATE OF BURIAL: May 27 1916

20. UNDERTAKER: Grossman and Ennes ADDRESS: T Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 14846
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls Ida.
City of Twin Falls

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jas. Hutchinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. (Month) 24 (Day) 1839 (Year)

7. AGE: 77 Yrs. 7 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession of particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: Willington

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Helen Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Andrew J. Hutchinson
(Address) Twin Falls Ida.

15. Filed 5/17 1916 J. F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21 1916, to May 27 1916, that I last saw him alive on May 27 1916, and that death occured on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:

Embolism
One hour
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr T. F. Galloway M. D.
5/27/1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 6 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence: Artesian City.

19. PLACE OF BURIAL OR REMOVAL: Artesian City Ida. DATE OF BURIAL: 5/28 1916

20. UNDERTAKER: Grossman & Evans. ADDRESS: Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 37

Primary Registration District No. 1085

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14847

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of " "

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melvin D. Crockett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the Word.): Single

6. DATE OF BIRTH. Feb 23 (Month) (Day) 1880 (Year)

7. AGE 36 Yrs. 3 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: Stock raising

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nevada

10. NAME OF FATHER: Edw. M. Crockett

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Phoebe A. Davis

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Hancock

(Address) Rock Creek

15. Filed May 30 1916 John F Coughlin Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24652

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 27th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21" 1916, to May 27" 1916, that I last saw him alive on May 27 1916, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Compression

..... (Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) D V Boyd M. D.

May 29 1916 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rock Creek — DATE OF BURIAL: 5-30 1916

20. UNDERTAKER: C J Crosby — ADDRESS: T Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 14848
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Miriam Clarke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1842 (Year)

7. AGE: 74 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin.

10. NAME OF FATHER: Wm Spencer.

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Dee

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. Arata
(Address) Twin Falls Ida.

15. Filed May 30 1916 John F. Gaynor Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1916, to May 29 1916, that I last saw h[illegible] alive on May 29 1916, and that death occured on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:

Bright's disease.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Hy Dougherty M. D.
5/29 1916 (Address) Twin Falls, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls, Idaho	May 30 1916
20. UNDERTAKER	ADDRESS
Grossman and Emery	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 14849
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella Ray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH. June (Month) 27 (Day) 1883 (Year)

7. AGE: 33 Yrs. 11 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kans.

10. NAME OF FATHER: James Johnson.

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Clara Williams

13. BIRTHPLACE OF MOTHER (State or Country): Vermont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hawley O. Ray.
(Address) Twin Falls Ida.

15. Filed June 13 1916 John S. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1916, to June 8 1916, that I last saw her alive on June 8 1916, and that death occured on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:

Acute Kidney Insufficiency
or Retention of Stomach

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary): Surgery of Appendix Cyst ruptured

(Duration ..... yrs. ..... mos. 25 ds.

(Signed) John R. Morgan, M. D.
June 19 16 (Address) Twin Falls, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: June 13 1916

20. UNDERTAKER: Grossman & Evans ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 14850
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Olof Leopold Maurits Mellin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. July 10 1839
(Month) (Day) (Year)

7. AGE: 77 Yrs. 11 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Wagon maker

9. BIRTHPLACE (State or Country): Stockholm Sweden

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Probably Sweden

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Probably Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Taken from effects
(Address): Globby Twin Falls

15. Filed June 15 1916 John F. Cowles Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 15 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1916, to June 14 1916, that I last saw h alive on June 14 1916, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia
Chronic Myocarditis
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Senility
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C Osgood M. D.
6-15 1916 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Twin Falls — DATE OF BURIAL: 6-15 1916

20. UNDERTAKER: C J Crosby — ADDRESS: Twin Falls

BYRD - RICHARDSON CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 14851
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roy C. McDougal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 6 (Day) 1893 (Year)

7. AGE: 23 Yrs. 3 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Teamster.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Colorado.

10. NAME OF FATHER A. H. McDougal.

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER R. Blair.

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. McDougal
(Address) Twin Falls Ida.

15. Filed June 16 1916 John L. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1916, to June 16 1916, that I last saw h alive on June 16 1916 and that death occured on the date stated above, at 5 9 M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Typhoid fever
..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) John L. Coughlin M. D.
6/16 1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: June 17 1916

20. UNDERTAKER: Grossman and Ernest — ADDRESS: Twin Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 716
File No. 14852
Registered No. 7

1. PLACE OF DEATH.
County of Bannock
City of Bancroft
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rhoda Haddan Rigby
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 17 (Day) 1841 (Year)

7. AGE: 31 yrs. 7 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Eland Murphy Stoddard

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sarah Ann Steed

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Rigby
(Address) Bancroft, Ida

15. Filed June 29 1916 D. J. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1916, to June 28 1916, that I last saw her alive on June 28 1916, and that death occurred on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever
(Duration) ..... yrs. ..... mos. 18 ds.
Contributory (Secondary) Myocarditis
(Duration) ..... yrs. ..... mos. 8 ds.
(Signed) W. J. Smith M. D.
June 29 1916 (Address) Bancroft, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chesterfield
DATE OF BURIAL: 7/2 1916

20. UNDERTAKER: none
ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2161
File No. 14853
Registered No. 65

1. PLACE OF DEATH.
County of Bannock
City of Bancroft
(No. ——, ——— St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Evelyn Frances Butterfield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 25 (Day) 1916 (Year)

7. AGE: ——yrs. ——mos. 1 ds. IF LESS than 1 day how many ——hrs. or 2 hrs. ——min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) none

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Albert J. Butterfield

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Nellie Fry

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. J. Butterfield
(Address) Bancroft

15. Filed 6/28 1916 R. N. J. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1916, to June 26 1916 that I last saw h er alive on June 26 1916, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Congestion
due to prolonged hard labor
(Duration) ——yrs. ——mos. ——ds.

Contributory (Secondary) .....
(Duration) ——yrs. ——mos. ——ds.

(Signed) R. N. J. Smith M. D.
6/28 1916 (Address) Bancroft

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ——yrs. ——mos. ——ds. In the State ——yrs. ——mos. ——ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bancroft
DATE OF BURIAL: 6/27 1916

20. UNDERTAKER: none
ADDRESS: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HYMS-YORK CO., PRINTERS & RINDERS. BOISE 18872

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 44
Primary Registration District No. 2121
(No. —, — St.)

File No. 21.
Registered No. 14854
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Don't know (Month) 1 (Day) 1845 (Year)

7. AGE: 71 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): United States

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D C Hall
(Address) Boise Idaho

15. Filed June 26 1916 J. C. Bartlett, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191—, to — 191—
that I last saw him alive on — 191—,
and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:

Apoplexy
Dept Insanity
(Duration) — yrs. — mos. — ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) J. C. Bartlett M. D.
6/26 1916 (Address) Burley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. ~~PLACE OF BURIAL~~ OR REMOVAL: Boise Idaho
DATE OF BURIAL: June 27 1916

20. UNDERTAKER: Soldiers' Home
ADDRESS: Boise
Fry & Summers

SYMS - YORK CO. PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14855
Registered No. 52

Registration District No. 9
Primary Registration District No. 2001

1. PLACE OF DEATH.
County of Ada
City of Star.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank L. Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W Wite.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married

6. DATE OF BIRTH. Apr (Month) 3 (Day) 1863 (Year)

7. AGE: 53 Yrs. 1 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio.

10. NAME OF FATHER Wm Williams

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Rachel Morgan

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. Myrle Williams
(Address) .....

15. Filed May 14 1916 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 13 (Month) (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 191 6, to June 191 6, that I last saw h..... alive on June 191 6, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pneumonia acute

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Geo Allen M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery. DATE OF BURIAL: May 14 1916

20. UNDERTAKER: Frye Summers Co ADDRESS: Boise Ida.

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 9

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14856
Registered No. 23

1. PLACE OF DEATH.

County of Ada

City of

(No. 6 Mile south of Star St.)

Registration District No. 2001

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Madison Carpenter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 6th (Day) 1858 (Year)

7. AGE: 58 Yrs. 5 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: not obtainable

11. BIRTHPLACE OF FATHER (State or Country): not obtainable

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Roy Elcarpenter

(Address) Eagle Idaho

15. Filed June 11 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1916, to June 30 1916, that I last saw him alive on June 1916, and that death occured on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows: Chronic inter stitial nephritis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Auricular fibrillation

(Duration 2 yrs. mos. ds.

(Signed) Maurice D. Johnson M. D.

June 19 16 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: June 11 1916

20. UNDERTAKER: Schreiber & Liebensteden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ....., ... St.)

File No. 14857
Registered No. 8

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pearl Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 28 (Day) 1915 (Year)

7. AGE ..... Yrs. 4 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Alva J. Williams

11. BIRTHPLACE OF FATHER (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: Alice Muir

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alva J. Williams
(Address) Shelley R.F.D. 2 Ida

15. Filed Feb. 26 1916 — M. E. Davis, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1916, to Feb 25 1916, that I last saw her alive on Feb 25 1916, and that death occured on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) — Yrs. — mos. 5 ds.

Contributory (Secondary): Whooping cough

(Duration ..... yrs. 1 mos. 6 ds.

(Signed) W W Beck M. D.

2/26 1916 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.C. Cem. Blackfoot — DATE OF BURIAL: Feb 28 1916

20. UNDERTAKER: Alva J Williams — ADDRESS: Shelley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

County of Bingham

Primary Registration District No. 2194

City of Blackfoot (No. RFD 4 (Groveland) St.)

File No. 14858

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annie Jacobson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: July (Month) (Day) 1831 (Year)

7. AGE: 84 yrs. 7 mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway.

10. NAME OF FATHER: don't know

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: don't know.

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M Jacobson

(Address) Blackfoot

15. Filed Jan 27 1916 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1916 to Jan 26 1916 that I last saw her alive on Jan 26 1916 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

myocarditis

chronic (Duration) 1 yrs. mos. ds.

Contributory (Secondary) Rheumatism

(Duration) yrs. mos. ds.

(Signed) H. J. Summers M. D.

1/26/16 19.16 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Maulard Idaho

DATE OF BURIAL: Jan 28 1916

20. UNDERTAKER: E J Funk

ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2190
File No. 14859
Registered No. 10

1. PLACE OF DEATH.
County of Bingham
City of Pingree
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Otis J Swope

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mail
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Mar

6. DATE OF BIRTH. Sept (Month) 1 (Day) 1886 (Year)

7. AGE: 29 Yrs. 5 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Phillips Co Kans

10. NAME OF FATHER: Christopher A Swope

11. BIRTHPLACE OF FATHER (State or Country): Holt Co Missouri

12. MAIDEN NAME OF MOTHER: Rosena J Swope Tim

13. BIRTHPLACE OF MOTHER (State or Country): Buchanan Co Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O J Swope
(Address) Pingree, Idaho

15. Filed Feb 29 1916 M. E. White Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Death investigated 191..., that I last saw deceased in attendance and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary)
(Duration — yrs. — mos. — ds.

(Signed) J B Davis M. D.
2/29 1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fremont County — DATE OF BURIAL: Feb 29 1916

20. UNDERTAKER: E J Funk — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 14860
Registered No. 7

1. PLACE OF DEATH
County of Bingham
City of Blackfoot RD # 3 (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Marlow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Jan (Month) 1 (Day) 1916 (Year)
7. AGE ... Yrs. ... Mos. ... ds. IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: P. Walton Marlow
11. BIRTHPLACE OF FATHER (State or Country): North Carolina
12. MAIDEN NAME OF MOTHER: Sarah Harriett Rudd
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P Walton Marlow
(Address) R # 3 Blackfoot Ida.
15. Filed Jan 2nd 1916 ... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 1 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916, to Jan 1 1916, that I last saw her alive on Jan 1 1916, and that death occured on the date stated above, at 10:45 P.M.
The CAUSE OF DEATH* was as follows:
Premature Birth
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration ... Yrs. ... mos. ... ds.
(Signed) A. W. Beck M. D.
1/2/1916 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: F.C. Cem. Blackfoot — DATE OF BURIAL: Jan 3 1916
20. UNDERTAKER: P Walton Marlow — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2191
File No. 14862
Registered No. 3

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry Trego

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Jan (Month) 10 (Day) 1916 (Year)

7. AGE: ... yrs. ... mos. 1 ds.
IF LESS than 1 day how many ... hrs. or ... mins.? 5

8. OCCUPATION
(a) Trade, profession or particular kind of work ...
(b) General nature of industry business, or dstablishment in which employed (or employer) ...

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Harry L Trego

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Minnie A Hoffine

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry L Trego
(Address) Blackfoot Idaho

15. Filed Jan 12 1916 M E Gatrie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1916, to Jan 11 1916, that I last saw him alive on Jan 11 1916, and that death occurred on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth Six Months

(Duration) ... yrs. ... mos. 1 ds.

Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) F. L. O. Mitchell M. D.
1/12 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Trego Ranch Groveland — DATE OF BURIAL: Jan 12 1916

20. UNDERTAKER: Harry L Trego — ADDRESS: Blackfoot Route 2.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14863

Registered No. 6

Registration District No. 121

Primary Registration District No. 2191

1. PLACE OF DEATH.

County of Bingham

City of Tabor (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gabriel Mueller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Married

6. DATE OF BIRTH. Unknown
(Month) (Day) 1 (Year)

7. AGE 76 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Common Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. W. F. Dresser
(Address) Tabor Ida

15. Filed Jan 24 1916 M E Palmer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January 20 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W B Davis M. D.

(Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Iona City Cemetery — DATE OF BURIAL: Jan 24 1916

20. UNDERTAKER: E Peck — ADDRESS: Blackfoot

STUBS-YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-1[illegible]-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14864

Registered No. [illegible]

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 1007

(No. City Limits St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank C Barker

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 1 (Day) 1867 (Year)

7. AGE: 48 Yrs. 11 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Painter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sparta Wisconsin

10. NAME OF FATHER Robert Barker

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harold Barker
(Address) Blackfoot Idaho

15. Filed Jan 24 1916 M. E. Stitt Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1915, to Jan 23 1916, that I last saw him alive on Dec 23 1915, and that death occured on the date stated above, at 1:20 P M.

The CAUSE OF DEATH* was as follows:

Sarcoma of Lungs

(Duration) 1 Yrs. 3 mos. ds.

Contributory (Secondary) Sarcoma of Tibia which was amputated

(Duration) 2 yrs. mos. ds.

(Signed) C W Beck M. D.

1/24 1916 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Iron City Cemetery — DATE OF BURIAL: Jan 26 1916

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14865
Registered No. 5

1. PLACE OF DEATH. Registration District No. 121
County of ..... Primary Registration District No. 2194
City of ..... (No. ....., Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ransom Nelson Conley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH 1 (Month) 21 (Day) 1916 (Year)

7. AGE 69 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work Farming & Stock raising
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Solomon M Conly

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Eva Merkley

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas A Campsey
(Address) Blackfoot

15. Filed Jan 22 1916 W E Lutes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 1 (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-18- 1916, to 1-21 1916
that I last saw him alive on 1-21 1916
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:

General Paralysis

(Duration) ..... yrs. 6 mos. ..... ds.
Contributory (Secondary) Dementia
(Duration) 2 5 yrs. ..... mos. ..... ds.
(Signed) Dow Poynter M. D.
1-21 1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place Ida Insane Asylum In the Blackfoot,
of death 7 yrs. ..... mos. 3 ds. State 25 yrs. ..... mos. ..... ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Montview Idaho — DATE OF BURIAL Jan 23 1916

20. UNDERTAKER E J Peck — ADDRESS Blackfoot

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 14866
Registered No. 12

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. Idaho Avenue St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dennis Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 30 (Day) 1863 (Year)

7. AGE: 52 Yrs. 2 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Fireman & Conductor
(b) General nature of industry, business, or establishment in which employed (or employer): O.S.L.R.R.

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Anthony Moore

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Collins

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William J Moore
(Address) Pocatello Ida

15. Filed Jan 5th 1916 — M. E. Davis, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1915, to July 7 1916, that I last saw him alive on July 7 1916, and that death occured on the date stated above, at 6 30 A.M.

The CAUSE OF DEATH* was as follows:
Bronch Pneumonia
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) L.O. Griffith
Acute Pneumonia
(Duration ..... yrs. ..... mos. 11 ds.
(Signed) Dr. Reynolds M. D.
19 ..... (Address) Blackfoot Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 7 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Pocatello Idaho
Former or usual residence Pocatello Idaho

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho — DATE OF BURIAL: Jan 9 1916

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14868

Registered No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. ....., ... St.)

2. FULL NAME Andrew J Vincent

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1844 (Year)

7. AGE: 72 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ky

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D M Poyner

(Address) Blackfoot Idaho

15. Filed March 21 1916 W E Watts Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 12 1916, to Mch 18 1916, that I last saw him alive on Mch 18 1916, and that death occured on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

Extinction

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senile Dementia

..... (Duration) unknown yrs. ..... mos. ..... ds.

(Signed) D M Poyner M. D.

19.... (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 1 mos. 6 days. In the State unknown ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? unknown

Former or usual residence Weiser Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ayslum Cemetery, Blackfoot Ida	March 20 1916
20. UNDERTAKER	**ADDRESS**
Julius L Dyer, Supervisor	Box 328 Blackfoot Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 1007

(No. .... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14869

Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Rekford

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence E. Carson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June 29 (Month) (Day) 1875 (Year)

7. AGE: 40 Yrs. 8 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Hotel Man

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Carson

11. BIRTHPLACE OF FATHER (State or Country): England 3-24

12. MAIDEN NAME OF MOTHER: Catherine Quail

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. Davis Hosp

(Address) Blackfoot Ida

15. Filed Mch 23 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 23 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21 1916, to Mch 23 1916, that I last saw h[illegible] alive on Mar 21 1916, and that death occured on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

1 (Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) B. Davis M. D.

1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lowland Idaho — DATE OF BURIAL: Mch 24 1916

20. UNDERTAKER: [illegible] — ADDRESS: Logan ut

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2190
File No. 14870
Registered No. 171

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tomus Garns Summers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): divorced

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 32 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labarer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: John Summers

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jos M. Clark
(Address) Roberts Idaho

15. Filed Mch 29 1916 M. E. Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 25 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24 1916, to March 25 1916, that I last saw ~~him~~ alive on March 25 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Brain Tumor

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Mitchell M. D.

3/29 1916 (Address) Blackfoot Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Groderly cemetery — DATE OF BURIAL: Mar 27 1916

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNE - YORK CO., PTRS. & BNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14871

Registered No. 18

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. Idaho Shoshone Caylor St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gertrude Walker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: 53 Yrs. 6 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. W. Poynter

(Address) Blackfoot Idaho

15. Filed Mch 29 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 27 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 6 1915, to Mch 27 1916, that I last saw her alive on March 26 1916, and that death occured on the date stated above, at 5-30 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Bones

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Mania Depressed Insanity

(Duration) 4 yrs. mos. ds.

(Signed) D. W. Poynter M. D.

3-29-1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 3 mos. 17 days. In the State 7 yrs. 8 mos. ..... days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Bonnie Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Helena Mont	3/29 1916

20. UNDERTAKER	ADDRESS
Goodheart	Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 14872
Registered No. 11

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Phillip Potter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1892 (Year)

7. AGE: 24 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Bank clerk
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER
(State or Country) Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. M. Poynter
(Address) Blackfoot Idaho

15. Filed Mch 4 1916 W. E. Petrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 6 1915, to Mch 2 1916, that I last saw h[illegible] alive on March 2 1916, and that death occured on the date stated above, at 4 45 P.M.

The CAUSE OF DEATH* was as follows:
Pleuro Pneumonia
(Duration) Unknown Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. M. Poynter M. D.
19 ..... (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 3 yrs. 10 mos. 17 days. In the State 14 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Unknown
Former or usual residence Caldwell

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery, Blackfoot Ida.
DATE OF BURIAL: March 4 1916

20. UNDERTAKER: Julius L Yeates
ADDRESS: Blackfoot Ida

Book 338

BYRNE - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ..... , ... St.)

File No. 14873
Registered No. 12

1. PLACE OF DEATH.
County of Bingham
City of Ferber

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Franklin Osborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Feb (Month) 18 (Day) 1866 (Year)

7. AGE: 50 Yrs. ..... Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Joel Osborn

11. BIRTHPLACE OF FATHER (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Lidia Parsen

13. BIRTHPLACE OF MOTHER (State or Country): N C O

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. A. Parsons
(Address) Blackfoot Idaho

15. Filed Mar 8 1916 .....
Local Registrar

3-8

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 2nd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from investigated to death, 191..., that I last saw h[illegible] as County Physician and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
found dead from
natural causes

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Davis M. D.
1916 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ferm City Cemetery — DATE OF BURIAL: Mar 8 1916

20. UNDERTAKER: E L Rick — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of [redacted]
BOARD OF [redacted]
Bureau of [redacted]

1. PLACE OF DEATH.

Registration District No. 121

File No. 14874

County of Bingham

Primary Registration District No. 6007

City of Blackfoot

(No. [redacted] West Judicial St.)

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME [redacted] Mrs. W. Davidson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 29 (Day) 1852 (Year)

7. AGE: 63 Yrs. 2 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home maker
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Portland Oregon

10. NAME OF FATHER: James Hill

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Harandin

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. E. Davidson
(Address) Blackfoot RFD 2

15. Filed Mch 15 1916 — W. O. Gillie, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1916, to Mch 14 1916, that I last saw h[illegible] alive on Mar 13 1916, and that death occured on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:
General Senility and
Mitral regurgitation

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Joseph B Davis M. D.
3-17 1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thomas Riverside Cemetery — DATE OF BURIAL: Mar 15 1916

20. UNDERTAKER: E. J. Rick — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 14875
Registered No.

1. PLACE OF DEATH.
County of Fremont
City of St Anthony (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Arthur Welker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 10 (Day) 1893 (Year)

7. AGE: 22 yrs. 6 mos. 4 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ~~Utah~~ Arizona

10. NAME OF FATHER: J. E. Welker

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sarah Thomock

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Percy Welker
(Address) Chester

15. Filed June 1 1916 W. DeVey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1916 to May 14 1916 that I last saw him alive on May 13 1916 and that death occurred on the date stated above, at 5 30 P.M.

The CAUSE OF DEATH* was as follows:

Cyanosis

(Duration) yrs. 2 mos. ds.
Contributory (Secondary) Influenza
(Duration) yrs. 4 mos. 6 ds.

(Signed) J. Mayfield M. D.
May 15 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Milford — DATE OF BURIAL: 5/16 1916

20. UNDERTAKER: Wm Yager — ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14876

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Franklin

City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 2177

(No. ....., ... St.)

2. FULL NAME Thomas Edwin Smith

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. June (Month) 26 (Day) 1850 (Year)

7. AGE: 65 Yrs. 10 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Farmington Utah

10. NAME OF FATHER: Thos J Smith

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Polly Isabell Clark

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) T E Smith Jr
(Address) St Anthony Ida

15. Filed June 10 1916 W Brent Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1916, to May 22 1916, that I last saw h in alive on May 22 1916, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Epileptic Exhaustion

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Paresis

(Duration ..... yrs. 9 mos. ..... ds.

(Signed) J Merrifield M. D.

5/26 1916 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Milford Cemetery — DATE OF BURIAL: May 27 1916

20. UNDERTAKER: None — ADDRESS: —

SYMS - YORK CO., PTRS. & ENGS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14877

Registered No. .....

Registration District No .....

Primary Registration District No .....

1. PLACE OF DEATH.

County of Adams

City of Meadows

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas. A. Powell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 5 (Day) 1850 (Year)

7. AGE: 65 Yrs. 7 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Gideon Powell

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Modora Hemm

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. J. Powell

(Address) Meadows Idaho

15.

Filed ..... 191....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1916, to May 5 1916, that I last saw h[illegible] alive on May 5 1916, and that death occured on the date stated above, at 11 50 P.M.

The CAUSE OF DEATH* was as follows:

Fracture of both Femurs
Sternum & 8 ribs Fractured

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Shock

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Simeon Hopper M. D.

19..... (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meadows Ida — DATE OF BURIAL: May 5 1916

20. UNDERTAKER: Northcutt & McEuen — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & ENGS. 24058

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14878

Registered No. .....

Registration District No. 9

Primary Registration District No. 2163

1. PLACE OF DEATH.

County of New Peace

City of Peck

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Pedersen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) V (Day) V 1 V (Year)

7. AGE: 49 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: V

11. BIRTHPLACE OF FATHER (State or Country): V

12. MAIDEN NAME OF MOTHER: V

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lynn Porter

(Address) Peck

15. Filed June 10 191 6 — J M Lyle, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Interstitial Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J M Lyle M. D.

19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston — DATE OF BURIAL: Nov 18 191 6

20. UNDERTAKER: Arthur Shaw — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 93
Primary Registration District No. 2371
File No. 14879
Registered No. ____

1. PLACE OF DEATH.
County of Nez Perce
City of Reubens R. 1
(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Mildred Garner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Married

6. DATE OF BIRTH.
Nov (Month) 22 (Day) 1874 (Year)

7. AGE
65 Yrs. 6 Mos. 18 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE
(State or Country) Missouri

10. NAME OF FATHER David Harness

11. BIRTHPLACE OF FATHER
(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Isibell Turner

13. BIRTHPLACE OF MOTHER
(State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W P Garner
(Address) Peck Idaho

15.
Filed 6-5 1916
J. McKyle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1916, to June 4 1916, that I last saw her alive on June 4 1916, and that death occured on the date stated above, at 8:30a M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ____ Yrs. ____ mos. 5 ds.
Contributory (Secondary) ____
(Duration ____ yrs. ____ mos. ____ ds.
(Signed) J. M. Kyle M. D.
6-7 1916 (Address) Peck Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Melrose Ida — DATE OF BURIAL: June 6 1916

20. UNDERTAKER ✓ — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14880

Registered No. .....

Registration District No 93

Primary Registration District No 2371

1. PLACE OF DEATH.

County of Lewis

City of Tesh

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fannie Logan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) V (Day) V 1..... (Year)

7. AGE 65 ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): V

10. NAME OF FATHER: V

11. BIRTHPLACE OF FATHER (State or Country): V

12. MAIDEN NAME OF MOTHER: V

13. BIRTHPLACE OF MOTHER (State or Country): V

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) No one knows anything of his people or friends.

(Address) .....

15. Filed 3-10 191 6

J. M. Lyle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 9 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows: (Common) Heart Failure

Found dead in Meadow Creek

..... (Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....

..... (Duration ... yrs. ... mos. ... ds.

(Signed) ..... M. D.

..... 19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Peck — DATE OF BURIAL: 3-11 191 6

20. UNDERTAKER: None — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14881
Registered No. 32

1. PLACE OF DEATH.
County of Wallace
City of Shoshone
(No. Wallace Hospital St.)
Registration District No. 20
Primary Registration District No. 1011
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Gust Olson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 41 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alma Lidbaum
(Address) Wallace Ida.

15. Filed JUN 10 1916 191...
F. Leo Zumpfe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1915, to June 7 1916
that I last saw h[illegible]m alive on June 7 1916
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) 1 yrs. 6 mos. ds.
Contributory (Secondary) [illegible] Alcoholism & Exposure
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Dr. Montgomery M.D.
June 9 1916 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho
DATE OF BURIAL: June 9 1916

20. UNDERTAKER: Bruce E. Worstell
ADDRESS: Wallace Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14882

Registered No. 53

1. PLACE OF DEATH

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011

(No. Providence Hosp't St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Gruncevich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: about 35 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): austria

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. E. Ward

(Address) Wallace Ida

15. Filed June 5 1916 F Leo Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 13 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191 , to June 13 191 , that I last saw him alive on June 13 1916 , and that death occured on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Shock & Hemorrhage

(Duration) Yrs. — Mos. Few hrs. ds.

Contributory (Secondary) Fracture of Back & Femur & Severe Contusions

(Duration) yrs. — mos. — ds.

(Signed) Dr. Moorhead M D

6/13/1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence Murray Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: June 15 1916

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & SONS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

Primary Registration District No. 1011

File No. 14883

Registered No. 54

County of Shoshone

City of Wallace (No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Green

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 22 (Day) 1916 (Year)

7. AGE: 58 Yrs. 9 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mining Man

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Africa

10. NAME OF FATHER: John Green

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Margaret Kerkman

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant):

(Address): Mrs. Jessie M. Green

15. Filed JUN 24 1916 191 ..... Local Registrar: F Leo Zunder

SVMS - YORK CO., PTRS. & BOBB. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1916, to June 22 1916, that I last saw h[illegible] alive on June 22 1916 and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) D Mowry M. D.

June 24 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Seattle Wash

19. PLACE OF BURIAL OR REMOVAL: Seattle Wash — DATE OF BURIAL: June 25 1916

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 22
Primary Registration District No. 2018
File No. 14887
Registered No. .....

1. PLACE OF DEATH.,
County of Gooding
City of Wendell
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME No Name

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb 16 1916 (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..3.. hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): -

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Fred W Best

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Effie Lena Wolford

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fred W Best
(Address) .....

15. Filed 5-1- 1916 E L Swanton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... 191.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from birth 191.., to death 191...,
that I last saw him alive on Feb 16 1916
and that death occured on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:

Immediate .....
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) E. L. Swanton M. D.
5-1 1916 (Address) Wendell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wendell Cemetary — DATE OF BURIAL: Feb 17 1916

20. UNDERTAKER: James Best — ADDRESS: Wendell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14888

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

1. PLACE OF DEATH.

County of Gooding

City of Wendell

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harvey Allen Best

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb 16 1916
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Fred W. Best

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Effie Lena Wofford

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fred W Best
(Address) .....

15. Filed Mar 11" 1916 E. L. Simonton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 4" 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 2 1916, to Mar 4 1916, that I last saw him alive on Mar 4" 1916 and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cold -

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) E. L. Simonton M. D.

5-1 1916 (Address) Wendell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wendell Cemetery

DATE OF BURIAL: Mar 5" 1916

20. UNDERTAKER: James Best -

ADDRESS: Wendell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BORS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 17

County of Kootenai

Primary Registration District No. 2051

City of Coeur d'Alene #2 (No. 6, St.)

File No. 14889

Registered No. 602

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Stewart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: February (Month) 25 (Day) 1836 (Year)

7. AGE: 79 yrs. 4 mos. 14 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Lumberman
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Mathew Stewart

11. BIRTHPLACE OF FATHER (State or Country): Newfoundland

12. MAIDEN NAME OF MOTHER: O Brien

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. M. H. Bigelow
(Address) 1821-2nd Ave Spokane

15. Filed 6/10 1916 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Died Suddenly no Doctor

Been ailing some time

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Drennan M. D.

6/9 1916 (Address) Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL ..... 191...

20. UNDERTAKER: Ott Stone — ADDRESS Rathdrum Ida

BYNS - YORK CO. PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1493

Registered No. .....

1. PLACE OF DEATH.

County of Gem

City of Emmett

Registration District No. 6

Primary Registration District No. .....

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Reed Adams

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. July (Month) 12 (Day) 1830 (Year)

7. AGE: 85 Yrs. 11 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) North Carolina

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Ida B. Swansett
(Address) Notus Idaho

15.
Filed 7/5 1916
G. A. Reynolds Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1915, to July 1916, that I last saw h.... alive on about July 1st 1916, and that death occured on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) Dont Know Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Cummings M. D.
7/4 1916 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 7/5 1916

20. UNDERTAKER: C. D. Bucknum — ADDRESS: Emmett

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14894

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6

Primary Registration District No. 7016

(No. ....., ... St.)

2. FULL NAME Martha A. Simpson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 55 years old ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Geo Sweeting

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Swanson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mert Jackson

(Address) Emmett Idaho

15.

Filed 5/25 1916

J. K. Raynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1916, to ~~Dec~~ July 21 1916, that I last saw her alive on Apr 5 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma of pelvic and contiguous viscera probably originating in uterus

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. N. Cummings M. D.

7-7-219-1 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bramwell Idaho

DATE OF BURIAL: 7/21 1916

20. UNDERTAKER: C. D. Bucknum

ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14895

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Ellen Whiteside

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Nov (Month) 8 (Day) 1908 (Year)

7. AGE 7 Yrs. 8 Mos. 13 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Thomas Whiteside

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Lida Campbell

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Leida Whiteside
(Address) Emmett Idaho

15. Filed 7/24/ 1916 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1916, to July 22 1916, that I last saw h-- alive on July 22 1916 and that death occured on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:
Tetanus

(Duration) ..... Yrs. ..... mos. ½ ds.
Contributory (Secondary) Penetrating Wound of foot

(Duration ..... yrs. ..... mos. 9 ds.

(Signed) J. L. Reynolds M. D.

7/24 1916. (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 7/25 1916

20. UNDERTAKER: C. D. Bucknum — ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14896

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gem

City of Emmett

(No. ....., ... St.)

Registration District No. 4

Primary Registration District No. 1410

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dewey Emanuel Twilegar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 11 (Day) 1898 (Year)

7. AGE: 18 Yrs. 1 Mos. 25 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: E. H. Twilegar

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Dollie V. Hayes

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. H. Twilegar
(Address) Emmett Idaho

15. Filed 7/7 191 6

J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 9.25 P.M.

The CAUSE OF DEATH* was as follows:
Acute dilitation of stomach
(determined by post mortem
Examination)
.....(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Nephritis (?)
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) A. N. Cummings M. D.
19.... (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 7/9 191 6

20. UNDERTAKER: C. Buckman — ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14897

Registered No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH.
County of Gooding
City of Gooding (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Seward

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
7 (Month) 6 (Day) 1916 (Year)

7. AGE
yrs. mos. 12 ds.
IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wilber Seward

11. BIRTHPLACE OF FATHER (State or Country) Wyoming

12. MAIDEN NAME OF MOTHER Ina Mulhall

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wilber Seward
(Address) Gooding

15.
Filed July -8- 1916 H. L. Corey M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
7 (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1916 to July 8 1916
that I last saw him alive on July 8 1916
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia, Double and Pneumonia, Influenza
(Duration) yrs. mos. 2 ds.
Contributory (Secondary) —
(Duration) yrs. mos. ds.
(Signed) H. E. Sarff M. D.
19 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding — DATE OF BURIAL: July -9- 1916

20. UNDERTAKER: A. Thompson — ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14898
Registered No.

1. PLACE OF DEATH. Registration District No.
County of Gooding Primary Registration District No.
City of Gooding (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esahell Fuller

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: 12 (Month) 11 (Day) 1871 (Year)

7. AGE: 45 yrs. 7 mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: Andrew Fancy

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edwin Fuller
(Address) Gooding

15. Filed June 27 1916 F. J. Carey M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1916, to June 27th 1916 that I last saw her alive on June 26th 1916 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Acute Ascending Paralysis

(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H E Lamph M. D.
June 27 1916 (Address) Gooding Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding — DATE OF BURIAL: June 27 1916

20. UNDERTAKER: A Thompson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 14899
Registered No. .....

1. PLACE OF DEATH.
County of Gooding
City of Gooding
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Frank Orlyn Carey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 6 (Month) — 4 (Day) — 1916 (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank Taylor Carey

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Ida Hayden

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ida Hayden Carey
(Address) Gooding Idaho

15.
Filed June 7 1916 F. T. Carey M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) — 7 (Day) — 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1916, to June 7 1916 that I last saw h. alive on June 7 1916, and that death occurred on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:

Interstate efates

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. T. Carey M. D.
June 7 1916 (Address) Gooding Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding Idaho. DATE OF BURIAL: June 8 1916

20. UNDERTAKER: A. E. Thompson ADDRESS: Gooding

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14900

Registered No.

1. PLACE OF DEATH.

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo Poling

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 15 (Day) 1853 (Year)

7. AGE: 62 yrs. 9 mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Newell Poling

11. BIRTHPLACE OF FATHER (State or Country): N. J.

12. MAIDEN NAME OF MOTHER: Anna Kelsey

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Geo Poling
(Address) Gooding Ida

15.
Filed July 8 1916 F. J. Carr M. D., Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1916 to May 20 1916, that I last saw him alive on May 19 1916, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Abscess of the lung following Empyema and Pneumonia
(Duration) yrs mos. 26 ds.
Contributory (Secondary) Influenza
(Duration) yrs mos. 4 ds.

(Signed) H E Lamb M. D.
19 (Address) Gooding, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone Ida. DATE OF BURIAL: May 22 1916

20. UNDERTAKER: A Thompson ADDRESS: Gooding

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State [redacted]
BOARD OF HE[redacted]
Bureau of Vital Statis[redacted]

1. PLACE OF DEATH.

Registration Distr[redacted]

County of Gooding

Primary Registration District No.

File No. 14901

City of Hagerman

(No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Horace Chas. Gridley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 2 (Month) 4 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 39 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank E. Gridley

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Rhoda Jane Warnick

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. G. Jeffreys

(Address) Hagerman Ida

15.

Filed Mar 1 1916 F. T. Carr M. D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from birth 1916 to 3-13 1916, that I last saw h[redacted] alive on 3-13 1916, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 7 ds.

Contributory (Secondary) Whooping Cough

(Duration) yrs. mos. 2 1 ds.

(Signed) O. G. Jeffreys M. D.

3-14 1916 (Address) Hagerman

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hagerman | DATE OF BURIAL: 3-15 1916

20. UNDERTAKER: none | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.

County of Gooding 4 Primary Registration District No.

File No. 14902

City of Gooding 4 (No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas James

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	White	Married

6. DATE OF BIRTH: May (Month) 9 (Day) 1862 (Year)

7. AGE: 53 yrs. 11 mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or datablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebr

10. NAME OF FATHER: Sam James

11. BIRTHPLACE OF FATHER (State or Country): Va

12. MAIDEN NAME OF MOTHER: R Pethaud

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) LeRoy James
(Address) Gooding

15. Filed July - 7 - 1916 F. J. Cary M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 5 (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28 1916, to May 2 1916 that I last saw h[illegible] alive on May 2 1916 and that death occurred on the date stated above, at 12-30 M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

Contributory —
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H E Lamb M. D.

19 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gooding	1916

20. UNDERTAKER	ADDRESS
A. Thompson	Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Fairfield
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58
Primary Registration District No. 2138
(No. ....., ... St.)

File No. 14903
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Newton Basterick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Nov. (Month) 9 (Day) 1834 (Year)

7. AGE: 81 yrs. 5 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner & Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: — Basterick

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. H. Banda
(Address) Fairfield Idaho

15.
Filed 4-15 1916 D O Higgs M D
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12th 1916, to April 15 1916, that I last saw him alive on April 14 1916, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Senility & Atheromatosis

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) — yrs. — mos. — ds.

(Signed) D O Higgs M. D.
4-15 1916 (Address) Fairfield Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lebanon Oregon
DATE OF BURIAL: 4-16 1916

20. UNDERTAKER: A E Thompson
ADDRESS: Fairfield Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

File No. 14904
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kasmich Bowers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Single

6. DATE OF BIRTH
Jan (Month) 7 (Day) 1903 (Year)

7. AGE
13 yrs. 3 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Norton Co Kansas

10. NAME OF FATHER Frank Bowers

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Ada Kingsbury

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ada Bowers
(Address) Gooding

15.
Filed July 7 1916 H. T. Carey M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
4 (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15th 1916, to April 16 1916, that I last saw him alive on — 191..., and that death occurred on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:
Sarcomas

(Duration) yrs. 6 mos. ds.
Contributory —
(Secondary)
(Duration) yrs. mos. ds.

(Signed) H. E. Lamb M. D.
19 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding | DATE OF BURIAL: 1916

20. UNDERTAKER: A Thompson | ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SONS. 1916O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.

County of Gooding Primary Registration District No.

City of Hagerman (No. , St.)

File No. 14905

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Stein

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH: Aug (Month) 11 (Day) 1911 (Year)

7. AGE: 4 yrs. 5 mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Abraham Wash

10. NAME OF FATHER Peter Stein

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Ora B. Lewis

13. BIRTHPLACE OF MOTHER (State or Country) Kans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. E. Coleman
(Address) Hagerman

15. Filed May 1 1916 F. T. Cary M.D., Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ 2-9-16 191 , to ~~191~~ , that I last saw him alive on 2-9-16 ~~191~~, and that death occurred on the date stated above, at 7 ~~13~~ M.

The CAUSE OF DEATH* was as follows:
Whooping Cough direct cause of death Cardiac dilatation
(Duration) yrs. mos. 14 ds.
Contributory (Secondary) Paralysis Infantile
(Duration) 4 yrs. mos. ds.
(Signed) R E Coleman M. D.
2-10 1916 (Address) Hagerman Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Ida | DATE OF BURIAL: 191

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1406
Registered No.

1. PLACE OF DEATH.
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. St.)

2. FULL NAME John Ray J Brinton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July 11 1910 (Month) (Day) (Year)

7. AGE: 5 yrs. 6 mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Gilbert E Brinton

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Nina Hoover

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Gilbert E Brinton
(Address): Gooding Ida.

15.
Filed July 7 1916 F. J. Cary M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 5th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30th 1916, to Feb 5th 1916, that I last saw h alive on Feb 5th 1916, and that death occurred on the date stated above, at 6-15 A M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 8 ds.

Contributory (Secondary): Influenza

(Duration) yrs. mos 2 ds.

(Signed) H. E. Lamb M. D.
Feb 6 1916 (Address) H E Lamb

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place ..... In the
of death ..... yrs ..... mos ..... ds. State ..... yrs ..... mos ..... ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding — DATE OF BURIAL: Feb 6th 1916

20. UNDERTAKER: R Thompson — ADDRESS: Gooding Ida

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14908

Registered No.

1. PLACE OF DEATH.

County of Gooding

City of

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Floyd Elton Henderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 24 (Day) 1898 (Year)

7. AGE: 17 yrs. 11 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Chauffer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Clinton Henderson

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Eva McMullen

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. E. Cutting
(Address) Gooding

15.
Filed Jan 18 1916
F. J. Cary M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) None
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. E. Lamb M. D.
Jan 18 1916 (Address) Gooding Ida.

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 1916

20. UNDERTAKER: G. E Thompson | ADDRESS: Gooding

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17149

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14909

Registered No.

1. PLACE OF DEATH.

County of Gooding

City of ~~Gooding~~ Beiss (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lite A Owens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: March 2 (Month) 1855 (Year)

7. AGE: 60 yrs. 10 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Proprietor of Hotel
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Lite Owens

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. L A Owens
(Address) Beiss Idaho

15.
Filed July 7 1916 F.T. Cary M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1915, to Jan 6 1916, that I last saw him alive on Jan 6 1916, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J.F. Cromwell M. D.

19 .... (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191 6

20. UNDERTAKER: A E Thompson | ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14910

Registered No.

Registration District No. 52

Primary Registration District No. 2136

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Green

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 18th (Day) 1916 (Year)

7. AGE: ~~yrs.~~ ~~mos.~~ ~~ds.~~ 5 Min

IF LESS than 1 day how many ..0.. hrs. or ..5.. mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Montpelier Idaho

10. NAME OF FATHER: Jesse Allen Green

11. BIRTHPLACE OF FATHER (State or Country): Vernel Utah

12. MAIDEN NAME OF MOTHER: Minnie Lee Fallick

13. BIRTHPLACE OF MOTHER (State or Country): Dingle Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Lynn M.D.
(Address) Montpelier Idaho

15.
Filed 7/19/ 1916 A. Hollingsead
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 191.., to ... 191.., that I last saw her alive on July 18 1916 and that death occurred on the date stated above, at 1.15 P.M.

The CAUSE OF DEATH* was as follows: Unknown

Prematurity 6 Month

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration) 1 yrs. ... mos. ... ds.

(Signed) J. H. Lynn M. D.

7/19 1916. (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos...days. In the State ...yrs...mos...days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier — DATE OF BURIAL: 7/19/ 1916

20. UNDERTAKER: Garbach — ADDRESS: Montpelier

GYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52

Primary Registration District No. 2136

File No. 14911

Registered No. .....

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Woodrow Wilson Adams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: June (Month) 20th (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wm O. Adams

11. BIRTHPLACE OF FATHER (State or Country) Louisville Ky

12. MAIDEN NAME OF MOTHER Jacboe

13. BIRTHPLACE OF MOTHER (State or Country) Moberly Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Florence Adams

(Address) Montpelier Idaho

15. Filed July 5th 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale
Blue baby

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Patent foramen

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. J. Funk M. D.

19.... (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Montpelier	7/6 1916

20. UNDERTAKER	ADDRESS
Dahlquist	Montpelier

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
(No. .... St.)

File No. 14912
Registered No. .....

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Caroline Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. April 6th 1833
(Month) (Day) (Year)

7. AGE: 83 Yrs. 3 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: James Johnson

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. E. Wright
(Address) Montpelier Ida

15. Filed July 14th 1916 — H. H. King, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 14th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1915, to July 1916, that I last saw her alive on July 13 1916, and that death occured on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:
Gastric Carcinoma

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary): Senility

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. H. King M. D.
7/14 1916 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida — DATE OF BURIAL: 7/15 1916

20. UNDERTAKER: H. Sarbach — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 2086
(No. ....., ... St.)

File No. 14914
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth Irene Hostetler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	W.	

6. DATE OF BIRTH: Dec. (Month) 11 (Day) 1915 (Year)

7. AGE: ..... yrs. 7 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Levi Hostetler

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Amanda Steele

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A A Newberry
(Address) Filer Ida

15. Filed July 21 1916 A A Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1916, to July 20 1916, that I last saw her alive on July 20 1916, and that death occurred on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:

Intussusception

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A A. Newberry M. D.
July 21 1916 (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Cemetery — DATE OF BURIAL ..... 191...

20. UNDERTAKER: F. E. Drake — ADDRESS Filer Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

31

DISINTERMENT PERMIT

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Ruth Irene Hostetler

now lying buried in Odd Fellow Cemetery, in the City or Town of Filer, Idaho

County of Twin Falls State of Idaho, who died on the ____ day of July 20, 1916, Aged ____ years ____ months

____ days, the cause of death being Bowels Telescoped and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever; or yellow fever as shown by the certificate of death of said deceased, given by

Dr. Newberry attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private
private or railway conveyance

to Sunset Memorial Park Cemetery in the City or Town of Twin Falls County of Twin Falls

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Twin Falls it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the Department of Public Health governing the Transportation of Corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the Department of Public Health at Boise, Idaho,

permit issued to:

this 3rd day of May, A.D. 1954.

W W Benson

Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of Twin Falls State of Idaho, this 14th day of May 1954.

H M Twiggs M.D.

Health Officer

Form DPH-48019

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2071
(No. ....., ... St.)

File No. 14915
Registered No. 54

1. PLACE OF DEATH.
County of Oneida
City of Malbrook
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leonard Wm Weitman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 30 1916 (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Joseph R. Weitman

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Hilda McDonald

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph R. Weitman
(Address) Malad Oneida Co. Idaho

15. Filed 5-4 1916 D. C. Ray Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 1 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 30 1916, to ..... 191..., that I last saw h[illegible] alive on Apr 30 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows: Premature birth

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. C. Ray M. D.
5/4 1916 (Address) Malad City, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad — DATE OF BURIAL: 5-5 1916

20. UNDERTAKER: John M. Richards — ADDRESS: Malad, Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 26

Primary Registration District No. 2069

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14916

Registered No. 78

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Oneida

City of Malad

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lenoy A. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 7 (Day) 1916 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 4 hours ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Malad

10. NAME OF FATHER: John A. Jones

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Mary Adams

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. Jones

(Address) Malad Idaho

15. Filed 5-8 1916 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 191 to ..... 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Akers M. D.

5/8 1916 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad, Idaho. DATE OF BURIAL: May 8 1916

20. UNDERTAKER: John M Pickard ADDRESS: Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BKBS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Oneida

City of Malad

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 216

Primary Registration District No. 2069

(No. ....., ... St.)

File No. 14917

Registered No. 76

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Jane Jenkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Jan. (Day) 20 (Year) 1867

7. AGE: 49 Yrs. 3 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: Thomas Jones

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Jane Moses

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. G. Jenkins

(Address) Malad Idaho

15.

Filed May 11 1916

D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 2 1916 to May 9 1916, that I last saw h.. alive on May 9 1916, and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Vagina

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs ..... mos. ..... ds.

(Signed) D C Ray M. D.

5/11/16 (Address) Malad City Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: May 13 1916

20. UNDERTAKER: John M. Richards — ADDRESS: Malad Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & STNRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 14919
Registered No. 178

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm D. Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH.
June (Month) 20 (Day) 1850 (Year)

7. AGE
65 Yrs. 10 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Wales

10. NAME OF FATHER John H. Williams

11. BIRTHPLACE OF FATHER
(State or Country) Wales

12. MAIDEN NAME OF MOTHER Sarah Davis

13. BIRTHPLACE OF MOTHER
(State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dan T. Williams
(Address) Malad City Ida.

15.
Filed 5-13 1916
D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 1916, to May 12 1916, that I last saw him alive on May 12 1916 and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular heart lesion

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.
May 13 1916 (Address) Malad City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad, Idaho. DATE OF BURIAL: May 14 1916

20. UNDERTAKER: John M. Richards ADDRESS: Malad Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 14920
Registered No. 19

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No. ....., ..., St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Emmett Enslow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 12 (Day) 1874 (Year)

7. AGE: 42 Yrs. 1 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Grain Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: David A. Enslow

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Margaret E. Hopper

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D A Enslow
(Address) Charlton Iowa

15. Filed 5-18 1916 D C Kay Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1916, to May 17 1916, that I last saw h[illegible] alive on May 17 1916, and that death occured on the date stated above, at 12:30 P M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs
(Duration) Yrs. 8 mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) J M Kerns M. D.
5/18 1916 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Charlton, Iowa — DATE OF BURIAL: May 19 1916

20. UNDERTAKER: John M. Richards — ADDRESS: Malad, Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 26

Primary Registration District No. 2069

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14921

Registered No. 20

1. PLACE OF DEATH.

County of Oneida

City of Jamaica

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Logan Tunnell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Married (Write the word.)

6. DATE OF BIRTH.

Mar. (Month) 16 (Day) 1856 (Year)

7. AGE

59 Yrs. 6 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Kentucky

10. NAME OF FATHER Bluford Tunnell

11. BIRTHPLACE OF FATHER

(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Lina Simpson

13. BIRTHPLACE OF MOTHER

(State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mattie Tunnell

(Address) Emmett Idaho

15.

Filed 1-23 1916

D C Kay
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1915, to May 22 1916, that I last saw him alive on May 21 1916, and that death occured on the date stated above, at 2a M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart lesions

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D C Kay M. D.

1-23 1916 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jamaica, Idaho — DATE OF BURIAL: May 24 1916

20. UNDERTAKER: John M. Richards — ADDRESS: Malad, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2077
File No. 1022
Registered No. 21

1. PLACE OF DEATH.
County of Oneida
City of Malbrook
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lars B Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	widowed

6. DATE OF BIRTH: Sept (Month) 12 (Day) 1833 (Year)

7. AGE: 82 yrs. 8 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Musician
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark.

10. NAME OF FATHER: Neils Burleson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Mary

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Helena Montana
(Address) Mrs J H Hicks

15. Filed 2-27 1916 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 16 1916 to May 25 1916
that I last saw h alive on May 25 1916
and that death occurred on the date stated above, at 2:15 M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D H Graham M. D.
2-25 1916 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Richfield Utah | DATE OF BURIAL ....191...

20. UNDERTAKER: J M Richards | ADDRESS Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of Malbrook
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 16
Primary Registration District No. 2071
(No. ..... St.)

File No. 14923
Registered No. 77
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
f	wh	

6. DATE OF BIRTH: 2 (Month) 6 (Day) 1916 (Year)

7. AGE: ..... yrs. 3 mos. 21 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: C
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Walter Johnson

11. BIRTHPLACE OF FATHER (State or Country): Ut

12. MAIDEN NAME OF MOTHER: Mary Utt

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L D Harvey
(Address) Malbrook Idaho

15. Filed 3-28 1916 D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 5 (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH was as follows:
Pneumonia
Acute Edema
Probably Bronchs pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) D C Ray M D
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Jas P Harrison Coroner M. D.
5/29 1916 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rust Idaho	5/29 1916

20. UNDERTAKER	ADDRESS
None	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 14924
Registered No. 28

1. PLACE OF DEATH.
County of Oneida
City of Malad

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Elizabeth Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. March (Month) 27 (Day) 1845 (Year)
7. AGE: 71 Yrs. 2 Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Wales
10. NAME OF FATHER: Richard Thomas
11. BIRTHPLACE OF FATHER (State or Country): Wales
12. MAIDEN NAME OF MOTHER: Morgan
13. BIRTHPLACE OF MOTHER (State or Country): Wales
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) T. J. Taylor
(Address) Malad, Idaho.
15.
Filed 5-30 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 5/27 1916, to 5/29 1916, that I last saw her alive on 5/29 1916 and that death occured on the date stated above, at 11.9 M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
5/30 1916 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad, Idaho — DATE OF BURIAL: May 30 1916
20. UNDERTAKER: John M. Richards — ADDRESS: Malad Idaho

SYMS - YORK CO., PTRS. & STRS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2091
File No. 1925
Registered No. 13

1. PLACE OF DEATH.
County of Oneida
City of Auden
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jackson Smith

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: April 7th 1915 (Month) (Day) (Year)

7. AGE: ✓ yrs. 1 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Infant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Oneida County Idaho

10. NAME OF FATHER Jay Smith

11. BIRTHPLACE OF FATHER (State or Country) Cedar Rapids Iowa

12. MAIDEN NAME OF MOTHER Susan E Goss

13. BIRTHPLACE OF MOTHER (State or Country) Webster Co Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Horace E Clayton
(Address) Auden Idaho

15. Filed 6-21 1916 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr 5th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17 1916, to Apr 5 1916
that I last saw him alive on Apr 1 1916
and that death occurred on the date stated above, at 2 A.M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D C Ray M. D.
Apr 5 1916 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Stone Idaho	4-7 1916

20. UNDERTAKER	ADDRESS
None	

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 1926
Registered No. 24

1. PLACE OF DEATH.

County of Oneida
City of Malad

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James M. Graham

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
July (Month) 14 (Day) 1843 (Year)

7. AGE
77 Yrs. 10 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) England

10. NAME OF FATHER
John Graham

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER
Elizabeth Johnson

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Eliza J. Graham
(Address) Malad Idaho

15.
Filed 6-5 1916
D C Reed
Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1916, to June 4 1916, that I last saw him alive on June 4 1916, and that death occured on the date stated above, at 11:50 A.M.

The CAUSE OF DEATH* was as follows:
Organic Heart Disease
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
6-5 1916 (Address) J. Allen Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston, Idaho
DATE OF BURIAL: 1916

20. UNDERTAKER: John M. Richards
ADDRESS: Malad, Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 1427
Registered No. 25

1. PLACE OF DEATH.
County of Oneida
City of Samaria
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Milton Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 1 1916 (Month) (Day) (Year)

7. AGE: ....Yrs. 2 Mos. 18 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Samaria, Idaho.

10. NAME OF FATHER Edgar Davis

11. BIRTHPLACE OF FATHER (State or Country) Samaria, Idaho.

12. MAIDEN NAME OF MOTHER Sarah Price

13. BIRTHPLACE OF MOTHER (State or Country) Samaria, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edgar Davis
(Address) Samaria Idaho

15. Filed 6-20 1916. D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1916, to June 19 1916, that I last saw him alive on 6-19 1916 and that death occured on the date stated above, at 11:10 P.M.

The CAUSE OF DEATH* was as follows:
Influenza
(Duration) ....Yrs. ....mos. 3 ds.
Contributory (Secondary)
(Duration ....yrs. ....mos. ....ds.
(Signed) D C Ray M. D.
6-20 1916 (Address) Malad City Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Samaria Idaho — DATE OF BURIAL: June 21 1916

20. UNDERTAKER: John M. Richards — ADDRESS: Malad Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 92

County of Nez Perce

Primary Registration District No. 2170

File No. 4 14032

City of ..... (No. ....., ... St.)

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wesley Byron Timmons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	single

6. DATE OF BIRTH

Oct 6 1914
(Month) (Day) (Year)

7. AGE

1 yrs. 9 mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... At home

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Henry B.Timmons

11. BIRTHPLACE OF FATHER (State or Country) Minn

12. MAIDEN NAME OF MOTHER Hester C.Denny

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H.B.Timmons

(Address) Gifford Idaho

15.

Filed July 30 1916 E.E.Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 29 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1916, to July 29 1916, that I last saw him alive on July 29 1916, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Double Pneumonia

(Duration) x yrs. x mos. 13 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E.E.Watts M. D.

7/29 1916 (Address) Gifford Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Reubens Idaho	7/30 1916

20. UNDERTAKER	ADDRESS
W.E.Stoddard	Gifford I

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 16

Primary Registration District No. 1016

(No. ____, ____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14935

Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lincoln

City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Wynn Hatch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m

4. COLOR OR RACE: white

5. ~~SINGLE, MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.)

6. DATE OF BIRTH. Jan 2 1915

1 year (Month) 6 (Day) 28 (Year)

7. AGE — Yrs. ..... Mos. 18 ds. 27

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Churchill

10. NAME OF FATHER Fred Hatch

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Myrtle Harding

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. E. Hatch

(Address) Shoshone

15. Filed July 31st 1916 J. K. Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1916, to July 30 1916, that I last saw h in alive on July 30 1916, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Drowning,

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

July 30 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL ..... 191...

20. UNDERTAKER: O. J. Brennan — ADDRESS Shoshone

EVANS, YORK CO., PRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1056
File No. 14936
Registered No. 111

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ysabel Gorrochea

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. May 18 1880
(Month) (Day) (Year)

7. AGE 36 yrs 2 mos 1 day
Yrs. Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Angel Gorrochea

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Juanca Arostegui

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Miguel Lecertua
(Address) .....

15. Filed July 20 1916
J. H. Treen
Local Registrar

EVANS-YORK CO., PTRS. & RULR. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July 20 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1916, to July 20 1916, that I last saw h[illegible] alive on July 20 1916, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Acute Cardiac Dilatation

(Duration) Yrs. 2 mos. 16 ds.
Contributory (Secondary) Valvular Stenosis
(Duration Yrs. mos. ds.

(Signed) [signature] M. D.
19 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: July 22 1916

20. UNDERTAKER: O. S. Brennan — ADDRESS: Shoshone

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 16

Primary Registration District No. 1916

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14937

Registered No. 13

1. PLACE OF DEATH.

County of Lincoln

City of Shoshone (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emmert Saidler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower

6. DATE OF BIRTH. Aug 30 1868

48 yrs 11 (Month) 11 (Day) 1 (Year)

7. AGE: 48 yrs 11 ms 1 day

.....Yrs. .....Mos. .....ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... N York State

9. BIRTHPLACE (State or Country) N Y

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clyde Saidler

(Address) .....

15. Filed July 31" 1916 J. L. Fuller Local Registrar

BYRNE - YORK CO., PTRS. & BOOK. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1916, to July 30 1916, that I last saw h alive on July 29 1916 and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Chronic Brights disease

.....(Duration) 1 Yrs. 3 mos. 10 ds.

Contributory (Secondary) Brights

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

July 31 1916 (Address) Shoshone Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone | DATE OF BURIAL: July 31 1916

20. UNDERTAKER: O. J. Brennan | ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
(No. ..... , ... St.)

File No. 14939
Registered No. 122

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Fredrickson Peterson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write word.)

6. DATE OF BIRTH.
Jan (Month) 3 (Day) 1870. (Year)

7. AGE
46 Yrs. 6 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Nurse.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Denmark.

10. NAME OF FATHER
Andrew Fredrickson

11. BIRTHPLACE OF FATHER
(State or Country) Denmark.

12. MAIDEN NAME OF MOTHER
Maria Madsen Fredrickson

13. BIRTHPLACE OF MOTHER
(State or Country) Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L C Anderson
(Address) Burley Cassia Co Idaho

15.
Filed July 12th 1916
Dr. J. C Patterson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to July 11 1916,
that I last saw h er alive on July 11 1916,
and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart
few hours
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Aortic Insufficiency
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) G R Smith M. D.
7/14 1916 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

17. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: July 14 1916.
20. UNDERTAKER: L. Gallagher — ADDRESS: Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Linden
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No. 2143
(No. ....., ... St.)

File No. 14911
Registered No. 31
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME June Lorraine Lyons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Single

6. DATE OF BIRTH: April (Month) 22 (Day) 9/6 1 (Year)

7. AGE: # yrs. 2 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Linden Idaho

10. NAME OF FATHER: Frank C. Lyons

11. BIRTHPLACE OF FATHER (State or Country): Calif

12. MAIDEN NAME OF MOTHER: Ida Sturdevant

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. C. Lyons
(Address) Linden Ida

15. Filed July 10 1916 J E Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4 1916, to July 7 1916, that I last saw h Lr alive on June 22 1916 and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* ~~was as follows~~:
Malnutrition
(Duration) ..... yrs. 2 mos. ..... ds.
Contributory (Secondary) General weakness prematine birth
(Duration) ..... yrs. 2 mos. 15 ds.

(Signed) J. E. Hoyt M. D.
July 10 1916 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cedar Creek Cemetery — DATE OF BURIAL: July 9 1916

20. UNDERTAKER: none — ADDRESS: —

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65
Primary Registration District No. 2145

File No. 14942
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles S Barnes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 18 (Day) 1876 (Year)

7. AGE: 39 yrs. 11 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): Self

9. BIRTHPLACE (State or Country): Ills

10. NAME OF FATHER: Daniel Barnes

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Carlina Blum

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Irey M Barnes
(Address) Potlatch Idaho

15. Filed Aug 2nd 1916 J. W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 7 (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-30 1916, to 7-30 1916, that I last saw him alive on 7-30 1916, and that death occurred on the date stated above, at 1 00 M.

The CAUSE OF DEATH* was as follows:
Shock following Injuries, Log rolled on [illegible] accident
(Duration) ..... yrs. ..... mos. 1 ds.
Contributory Heart Disease
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) I S McPaul M. D.
7-31 1916 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rock Creek — DATE OF BURIAL: Aug 3 1916

20. UNDERTAKER: E Anderson — ADDRESS: Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14943

Registered No. .....

Registration District No. 65.

Primary Registration District No. 2145.

1. PLACE OF DEATH.

County of Latah.

City of Princeton

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant son of Willard Heaton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH. July (Month) 13 (Day) 1916 (Year)

7. AGE: ..... Yrs. ✓ Mos. ✓ ds.

IF LESS than 1 day how many 12 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Willard. Heaton.

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Marie Hansen.

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Willard. Heaton

(Address) Princeton Idaho.

15. Filed July 14 191.. D. Jno. Thompson Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13th 1916, to July 13 - 1916, that I last saw him alive on July 13. 1916, and that death occured on the date stated above, at 6 0 M.

The CAUSE OF DEATH* was as follows:

Morbus. Caeruleus.

..... (Duration) ..... Yrs. ..... mos. 12 hrs. ds.

Contributory (Secondary) Premature Birth.

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J.W. Thompson. M. D.

July 14 1916. (Address) Potlatch Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery. DATE OF BURIAL: July. 14. 1916

20. UNDERTAKER: Parents. ADDRESS: Princeton Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65
Primary Registration District No. 2145
(No. St.)

File No. 14914
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Suesing

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Aug (Month) 17 (Day) 1870 (Year)

7. AGE: 45 yrs. 11 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ontario

10. NAME OF FATHER: Valentine Suesing

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Christiana Christensen

13. BIRTHPLACE OF MOTHER (State or Country): Ontario

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Suesing
(Address) Pleasant Wn

15. Filed July 31 1916 J.W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 7 (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-27 1916, to 7-29 1916, that I last saw him alive on 7-29 1916, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pleurisy

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. S. Evans M. D.
7/30 1916 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash. DATE OF BURIAL: July 31 1916

20. UNDERTAKER: P. Gunderson. ADDRESS: Palouse, Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

46 y aug

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14945
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Freers
Registration District No. 65
Primary Registration District No. 2146
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amanda E Lang

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 5 (Day) 1879 (Year)

7. AGE: 36 yrs. 8 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Cashur Cauger

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Helen Burlingham

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R E Leonard
(Address) Palouse Wash

15.
Filed July 19 1916 D. Jr. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1915, to July 18 1916
that I last saw her alive on July 18 1916
and that death occurred on the date stated above, at 1045 M.

The CAUSE OF DEATH* was as follows:
Tuberculos peritonitis

..... (Duration) 3 yrs. ..... mos. ..... ds.
Contributory (Secondary) Nephritis. Mal nourishment
..... (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) D R Harrison M. D.
July 18 1916 (Address) Palouse Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Freers Cemetary
DATE OF BURIAL: July 20 1916

20. UNDERTAKER: E Anderson
ADDRESS: Palouse

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14946

Registered No. 48

Registration District No. 61

Primary Registration District No. 1011

(No. ..... St.)

1. PLACE OF DEATH.

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily Clarandia Boetwick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 11 (Day) 1843 (Year)

7. AGE: 73 Yrs. ..... Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER Ephriam Dyer

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Belinda Taylor

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lulu Boetwick Childers

(Address) Moscow Idaho

15. Filed July 26 1916

S. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28, 1916, to July 25, 1916, that I last saw her alive on July 18, 1916, and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Rheumatism

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritzmacher M. D.

7/26 1916 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow

DATE OF BURIAL: July 26 1916

20. UNDERTAKER: Glen Grice

ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Moscow

Registration District No. 67

Primary Registration District No. 1011

(No. ....., ... St.)

File No. 14917

Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lambert Hastings Ayer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Oct. 26 (Month) 1842 (Day) (Year)

7. AGE: 73 Yrs. 8 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: agriculturist.
(b) General nature of industry, business, or establishment in which employed (or employer): " "

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Royal Ayer

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Rosanna Bugbee

13. BIRTHPLACE OF MOTHER (State or Country): Connecticut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Mary A. Ayer
(Address) Moscow Idaho

15. Filed July 19 1916 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 9 1916, to July 17th 1916, that I last saw him alive on July 17th 1916, and that death occured on the date stated above, at 1.10 P.M.

The CAUSE OF DEATH* was as follows:

Fatty degeneration of the heart

(Duration) Yrs. 8 mos. — ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Wise M. D.

Mch 9 1916 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: July 20 1916

20. UNDERTAKER: Glen C Guice — ADDRESS: Moscow

SYMS - YORK CO., PTRS. & STRS. 24853

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 61

Primary Registration District No. 2141

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14918

Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mr Charles Goetz

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 13 (Day) 1847 (Year)

7. AGE 69 Yrs. 6 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Frankfurt-on-the-Main Germany

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. Erickson

(Address) Moscow

15. Filed July 18 1916 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) – 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-17 1916, to 7-17 1916, that I last saw h.. alive on 7-17 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Unknown

History-Complained of dizziness some days previous

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. C. L. Erickson M. D.

7-18 1916. (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Viola — DATE OF BURIAL: July 19 1916

20. UNDERTAKER: Ed Anderson — ADDRESS: Palouse

BYRNE - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 14949
Registered No. 76

1. PLACE OF DEATH
County of Latah Co
City of Moscow, Idaho (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benj Franklin McConnell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept 14th 1867 (Month) (Day) (Year)

7. AGE: 48 Yrs. 9 Mos. 25 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Fredonia Humboldt Co Calif

10. NAME OF FATHER: Wm J McConnell

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Lucinda Lyons

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Maria M. Bond
(Address) Boise Ida

15. Filed July 10 1916 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 9th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1916, to July 8th 1916, that I last saw him alive on July 8th 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs
(Duration) Yrs. 7 mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W. A. Cedar M. D.
July 9th 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: July 10 1916

20. UNDERTAKER: Lee & Price — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - WEBB CO., PTRS. & STNRS. 84253

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36

Primary Registration District No.

(No. ..... , ... St.)

File No. 14951

Registered No. 25

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of Buhl

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doris Tuttle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH. June 15 1916 (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... ✓

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Guy Porter

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Helen Tuttle

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Tuttle

(Address) Buhl Idaho

15. Filed July 30 1916 J. M. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1916, to June 15 1916, that I last saw her alive on June 15 1916, and that death occured on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) 30 minutes yrs. mos. ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos, ... ds.

(Signed) W. R. Wallentine M. D.

6-28-1916 (Address) Buhl Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Buhl — DATE OF BURIAL Not given 191

20. UNDERTAKER None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 14953
Registered No. 21

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm E Graham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH
Married (Month) 28 (Day) 1855 (Year)

7. AGE
61 yrs. 4 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Furniture and
(b) General nature of industry business, or establishment in which employed (or employer) Un dertaker

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER James H. Graham

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Frances Ann Wyrick

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mable Wesley
(Address) Grangeville Ida.

15. Filed Aug 10 1916 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1916, to July 21 1916, that I last saw him alive on July 21 1916, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Shock following fall resulting in fracture of 3 ribs and st. Co Innominata
(Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) none
(Duration) ..... yrs. ..... mos. 1 ds.
(Signed) C N Swanson M. D.
July 21 1916 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paine View — DATE OF BURIAL: July 23 1916

20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14954

Registered No. 73

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls, (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Blough

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 22 (Day) 1910 (Year)

7. AGE: 6 Yrs. 7 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Bowen Minn.

10. NAME OF FATHER Clay C. Blough

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Magdalen Sadir

13. BIRTHPLACE OF MOTHER (State or Country) Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clay C. Blough

(Address) Idaho Falls Ida

15.

Filed Aug 11 1916

Local Registrar

SVMS - YORK CO., PTRS. & SONS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8 1916, to Aug 9 1916, that I last saw her alive on Aug 9 1916, and that death occured on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Gastro Enteritis

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) C. Townsend M. D.

8/11 1916 (Address) Ida Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill. DATE OF BURIAL: Aug 13 1916

20. UNDERTAKER: G. H. Hunt ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14955

Registered No. 72

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls. (No. ....., ... St.)

Registration District No. 73

Primary Registration District No. 140

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Silas Delos Dean.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Dec (Month) 11 (Day) 1914 (Year)

7. AGE: 1 Yrs. 7 Mos. 28 ds.

If LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: S. H. Dean.

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Ella Applegate.

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S. H. Dean.
(Address) Idaho Falls. Idaho.

15.
Filed Aug 10 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 4 1916, to Aug. 8 1916, that I last saw him alive on 8-8 1916, and that death occured on the date stated above, at 5-15 M.

The CAUSE OF DEATH* was as follows:

Infantile paralysis.

(Duration) - Yrs. - mos. 4 ds.

Contributory (Secondary): none

(Duration) - yrs. - mos. - ds.

(Signed) F. H. Coulthard M. D.

19.... (Address) Idaho Falls. Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cem. DATE OF BURIAL: Aug. 9- 1916.

20. UNDERTAKER: J. F. Judd. ADDRESS: Idaho Falls. Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho Falls. Registration District No. 73

City of Bonneville. Primary Registration District No. 3157

(No. ....., 2 St.)

File No. 14256

Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry J. Haymond.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH. Oct. 2 (Month) (Day) 1863 (Year)

7. AGE: 73 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana.

10. NAME OF FATHER: H. J. Haymond.

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Wible

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. J. Haymond

(Address) Idaho Falls, Idaho

15.

Filed Aug 10 1916 Compton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 1916, to Aug. 7 1916, that I last saw h— alive on Aug 7 1916, and that death occured on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Price M. D.

19.... (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Atlanta Idaho — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: W. H. Jenks. — ADDRESS: Idaho Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Ida Pendleton

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14957

Registered No. 78

Registration District No. 73

Primary Registration District No. 2102

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Iona

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lizzie Annie Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 23 March 1868 (Month) (Day) (Year)

7. AGE 48 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed or employer):

9. BIRTHPLACE (State or Country): Alabama

10. NAME OF FATHER: Willis Sellers.

11. BIRTHPLACE OF FATHER (State or Country): Alabama.

12. MAIDEN NAME OF MOTHER: Sara Stamps.

13. BIRTHPLACE OF MOTHER (State or Country): Mississippi

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James A Smith

(Address) Iona Idaho

15.

Filed Aug 10 1916

County Recorder
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 5 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1916, to June 5 1916, that I last saw h on alive on June 5 1916 and that death occured on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Acute Rheumatism

(Duration) ——— Yrs. ——— mos. 21 ds.

Contributory (Secondary) Catarrhal Pneumonia

(Duration) ——— yrs. ——— mos. 8 ds.

(Signed) G W Pendleton M. D.

June 1916 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Iona Cem. DATE OF BURIAL: June 7 1916

20. UNDERTAKER: W H Gould ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 0 - 6
(No. ..... St.)

File No. 14958
Registered No. 629

1. PLACE OF DEATH.
County of Idaho Falls
City of Bonneville

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella Mulburn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Dec. (Month) 22 (Day) 1 (Year)

7. AGE
66 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: William Baker

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Fulton

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm. Mulburn
(Address) Idaho Falls

15.
Filed July 17 1916
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 8 a M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Duration ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. Jepsen M. D.
July 17 1916 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: July 17 1916

20. UNDERTAKER: G. H. Hunt — ADDRESS: Idaho Falls

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1459
Registered No. 67

1. PLACE OF DEATH.
County of Bonneville
City of Ammon
(No. 0, St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2 1 1 - a

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frances M Bale

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec 12 (Month) (Day) 1893 (Year)

7. AGE: 22 yrs. 7 mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: D. F. De Long

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Elsie Maudeson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Guy Fennimore
(Address) Idaho Falls Ida

15. Filed July 14 1916 Guy Fennimore Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1916, to July 13 1916, that I last saw her alive on July 11 1916, and that death occurred on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:
Interstitial Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Guy Fennimore M. D.
7/14 1916 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls
DATE OF BURIAL: 7/16 1916

20. UNDERTAKER: C E Dunwoody
ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SEMS - YORK CO., PRINT & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of States
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 106
Primary Registration District No. 2184
(No. ....., ... St.)

File No. 14960
Registered No. 44
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rachel Corbett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	Indian	Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1903 (Year)

7. AGE
13 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Child
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Silas J Corbett

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Ellen James

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rev. Dickson
(Address) States

15.
Filed Aug 5 1916 J.M. Verbeke
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1916 to July 29 1916, that I last saw h.. alive on July 13 1916, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Tuberculosis lungs

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H H Neuworth M. D.
July 29 1916 (Address) States

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kamiah — DATE OF BURIAL: July 31 1916

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14961

Registered No. 36

1. PLACE OF DEATH.

County of Bonner

City of Priest River

Registration District No. 81

Primary Registration District No. 2158

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lizzie Fust

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Femal.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 29 (Day) 1883 (Year)

7. AGE: 32 Yrs. 11 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: T. W McLaughlin

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Ellen Halvey

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. E. Fust

(Address) Priest River.

15. Filed July 25 1916

E D McCarty
Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1916, to July 24 1916, that I last saw h[illegible] alive on July 24 1916, and that death occured on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Dilitation of heart Mitral Regurgitation
Chronic Valvular disease (Rheumatism)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Acnemia

(Duration ..... yrs. ..... mos 24 ds.

(Signed) E. D. McCarty M. D.

7/24 1916 (Address) Priest River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF [illegible] OR REMOVAL: Bonners Ferry

DATE OF BURIAL: 191

20. UNDERTAKER: R. H. Bray (142)

ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 81
Primary Registration District No. 2/58
(No. ..... St.)

File No. 14962
Registered No. 37

1. PLACE OF DEATH.

County of Bonner
City of Oldus

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lewis A. A. Tonnett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 27 (Day) 1866 (Year)

7. AGE: 50 Yrs. 0 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) France

10. NAME OF FATHER Henry Tonnett

11. BIRTHPLACE OF FATHER (State or Country) France

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lillian Tonnett
(Address) Calen Idaho

15. Filed July 31 1916 E D McCarty Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1916, to July 30 1916, that I last saw h[im] alive on July 30 1916, and that death occured on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:
Peritonitis Gangrenous appendicitis

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Chronic Appendicitis
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E D McCarty, M. D.
July 31 1916 (Address) Priest River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: July 31 1916

20. UNDERTAKER: E M Brouner ADDRESS: —

SYMS - YORK CO., PTRS. & ENGR. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14963

Registered No. 76

1. PLACE OF DEATH.

Registration District No. 90

Primary Registration District No. 768

County of Clearwater

City of Orofino Ida

(No. Northern Idaho Sanitarium St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. (Month) — (Day) — 1853 (Year)

7. AGE: 61 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner & Dishwasher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Givens
(Address)

15. Filed Aug 17 1916 J M Finley Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19 1916, to July 9th 1916, that I last saw him alive on July 9th 1916, and that death occured on the date stated above, at 5-45 P.M.

The CAUSE OF DEATH* was as follows:
Arterio - sclerosis

9
(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) Insanity

(Duration) — yrs. 4 mos. 20 ds.

(Signed) John Givens M. D.

4/10 1916 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. 4 mos. 20 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: July 12 1916

20. UNDERTAKER: P. M. Johnson — ADDRESS: Orofino, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Grafino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 40
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 14964
Registered No. 37
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lauren M. Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
March 29 1881
(Month) (Day) (Year)

7. AGE
35 yrs. 3 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER William Taylor.

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Ellis.

13. BIRTHPLACE OF MOTHER (State or Country) Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martha A Vinson
(Address) Farmington Wash

15.
Filed July 8 1916 J. M. Fairley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July 11 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191 , to — 191 , that I last saw h— alive on July 8 about 1916, and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Accidental death from explosion

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory —
(Secondary)

— (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Fairley M. D.
7/18 1916 (Address) Grafino, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Mineral Ida — DATE OF BURIAL: 7/19 1916

20. UNDERTAKER: H. A. Shoen — ADDRESS: Grafino

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 768
File No. 14965
Registered No. 38

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. North Idaho Sanitarium St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clarence Madsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucassian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. (Month) (Day) 1846 (Year)

7. AGE: 70 Yrs. — Mos. — ds. —
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming and
(b) General nature of industry, business, or establishment in which employed (or employer): Stock Raising

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Clemens
(Address)

15. Filed Aug 17 1916
J. M. Daily
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July 15" (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1909, to July 15" 1916, that I last saw him alive on July 15" 1916, and that death occured on the date stated above, at 5:20 P.M.
The CAUSE OF DEATH* was as follows:

Hemi-Plegia

(Duration) 7 Yrs. 2 mos. 13 ds.
Contributory (Secondary) Insanity
(Duration) 7 yrs. 2 mos. 13 ds.

(Signed) John Clemens M. D.
July 15 1916 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 7 yrs. 2 mos. 13 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Kamiah

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: July 18" 1916
20. UNDERTAKER: P. M. Johnson — ADDRESS: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14966

Registered No. 39

Registration District No. 90

Primary Registration District No. 2168

(No. North Idaho Sanitarium St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Clearwater

City of Orofino Ida.

2. FULL NAME Frank Levi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. — (Month) — (Day) 1 1850 (Year)

7. AGE: 66 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Elk Rapids, Mich

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Livingston

(Address) Orofino, Ida

15. Filed Aug 17 1916 M. Faith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 18" 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 9" 1916, to July 18 1916, that I last saw h-im alive on July 17 1916, and that death occured on the date stated above, at 8 05 P.M.

The CAUSE OF DEATH* was as follows:

General Paresis

(Duration) — Yrs. 9 mos. 9 ds.

Contributory (Secondary) Insanity

(Duration — yrs. 9 mos. 9 ds.

(Signed) John Livingston M. D.

July 18 1916 (Address) Orofino, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. —yrs. 9 mos. 9 days. In the State —yrs. —mos. —days

Where was disease contracted if not at place of death?.....

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: July 20 1916

20. UNDERTAKER: P. M. Johnson — ADDRESS: Orofino Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

Registration District No. 48

Primary Registration District No. 2127

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14967

Registered No. .....

1. PLACE OF DEATH.

County of Lemhi

City of Reubens

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mary Alice Patterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: November 18 (Month) (Day) 1913 (Year)

7. AGE: 3 yrs. 7 mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: #
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweetwater, Idaho

10. NAME OF FATHER: C. A. Patterson

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Rosa Kirk

13. BIRTHPLACE OF MOTHER (State or Country): Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles A Patterson
(Address) Reubens, Idaho

15.
Filed July 2nd 1916. Ellen B. Rogers Local Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 1st (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1916, to July 1st 1916, that I last saw her alive on July 1st 1916 and that death occurred on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

..... (Duration) ..... yrs. two mos. ..... ds.

Contributory (Secondary) Rheumatism

..... (Duration) ..... yrs. 7 mos. ..... ds.

(Signed) Ellen B. Rogers M. D.

July 2nd 1916. (Address) Ulmbester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Baily Cemetery

DATE OF BURIAL: July 3rd 1916

20. UNDERTAKER: none

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SMITH-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14968
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Lincoln
City of Jerome
(No. , St.)
Registration District No.
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph Moore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Nov. (Month) 26 (Day) 1873 (Year)

7. AGE
42 yrs. 7 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Merchant & Banker
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Sam'l F. Moore

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Lavina Jones

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ruby W. Gillespie
(Address) Jerome Idaho

15.
Filed July 1 1916 E. D. Piper Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1916, to June 29 1916, that I last saw him alive on June 29 1916, and that death occurred on the date stated above, at 9P. M.

The CAUSE OF DEATH* was as follows:
Acute Tonsillitis and acute infection of Frontal Sinus terminating in Acute Inflamatory Rheumatism
(Duration) yrs. mos. 4 ds.
Contributory Myocarditis
(Secondary)
(Duration) yrs. mos. 30 ds.
(Signed) E. D. Piper M. D.
7/1 1916 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~ Jerome Cemetery | DATE OF BURIAL 7/1 1916

20. UNDERTAKER D. A. Davidson | ADDRESS Jerome Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Jerome
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

File No. 14969
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Georgie Manner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Male	White	Single

6. DATE OF BIRTH
March (Month) 27 (Day) 1911 (Year)

7. AGE
5 yrs. 2 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Chas D. Manner

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Agusta Barthold

13. BIRTHPLACE OF MOTHER (State or Country) Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas D Manner
(Address) Jerome

15.
Filed June 24 1916 E. D. Piper Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1916, to June 23 1916, that I last saw him alive on June 22 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(Duration) 5 yrs. ..... mos. ..... ds.

Contributory Insanity
(Secondary)

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) John F. Schmerse Jr. M. D.
June 23 1916 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jerome Cemetery	6-24-1916

20. UNDERTAKER	ADDRESS
D. M. Harrison	Jerome Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 1004

Primary Registration District No. 1004

(No. 2402 Bannock St. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14971

Registered No. 180

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Boise

City of Ada County

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Monroe Eckert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. August 13 (Month) (Day) 1863 (Year)

7. AGE: 52 Yrs. 11 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: yard master

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: John Eckert

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Nancy Gonner

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Mrs. Sellars

(Address): 2402 Bannock St. Boise Ida

15. Filed July 31 1916 — E. H. Slade Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 29th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29, 1916, to July 29, 1916, that I last saw him alive on July 29th 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... Yrs. ..... mos. ..... ds.

(Signed) E. H. Slade M. D.

7/31 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence: Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 7/31 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

Dr. Smith

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., BYRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 14972
Registered No. 179

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 919 W Franklin St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edmund Hooker Beggs.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH. Mar (Month) 8th (Day) 1865 (Year)

7. AGE 51 Yrs. 4 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired Capitalist
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Checksar Co, Iowa

10. NAME OF FATHER L. E. Beggs

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Hannett Jones

13. BIRTHPLACE OF MOTHER (State or Country) Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hall C. Beggs
(Address) .....

15. Filed 7/31 1916
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 29th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1915, to July 1916, that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....
(Duration ... yrs. ... mos. ... ds.

(Signed) Jno Calvert M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Boise, Idaho,

19. PLACE OF BURIAL OR REMOVAL: Morris at Dr's Williams Cals. DATE OF BURIAL: July 31 1916

20. UNDERTAKER Schreiber & Siddenfaden ADDRESS Boise Ida

Dr. Cottrell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14973

Registered No. 178

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No 2

Primary Registration District No 1004

(No. 1502 Jefferson St.)

2. FULL NAME Hattie M. Pefley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Aug (Month) 1 (Day) 1867 (Year)

7. AGE: 48 Yrs. 11 Mos. 24 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER Homer Smith.

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Sarah McFarlane.

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harlan Pefley
(Address) Boise, Idaho

15. Filed 7/31 1916

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ July 25 1916, to ~~191~~, that I last saw her alive on ~~died~~ July 25 1916, and that death occured on the date stated above, at 9.30 P.M.

The CAUSE OF DEATH* was as follows:

Suicide. Cyanide of Potassium Poison

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) Clyde E. Summers Coroner A.M.D.

7/31 1916 (Address) Boise Idaho County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portland Ore

DATE OF BURIAL: Aug 1 1916

20. UNDERTAKER: Geo Summers

ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 14974
Registered No. 177

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 704 S. 17th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William A. Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 2nd (Day) 1862 (Year)

7. AGE 57 Yrs. 10 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wis.

10. NAME OF FATHER John W. Wilson

11. BIRTHPLACE OF FATHER (State or Country) Ann.

12. MAIDEN NAME OF MOTHER Susan Parker

13. BIRTHPLACE OF MOTHER (State or Country) Ann.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Viola B Wilson

15. Filed 7/29 1916

Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 28 (Month) (Day) 1916 (Year)

I HEREBY CERTIFY, That I attended deceased from July 28 1916 to July 28 1916, that I last saw h— alive on July 28 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Valvular Heart disease
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R E Lynch M. D.
July 29 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 7/31 1916

20. UNDERTAKER: Schreiber & Siebenfaden — ADDRESS: Boise, Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14975

Registered No. 176

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 219 W. Springs Ave)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Johnnie Lucel Brassfield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 12 (Day) 1904 (Year)

7. AGE: 12 Yrs. 1 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Jared Brassfield

11. BIRTHPLACE OF FATHER (State or Country): Kas.

12. MAIDEN NAME OF MOTHER: Lucie Brown

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jared G Brassfield

(Address) South Boise

15.

Filed 7/29 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 28 (Day) 1916 (Year)

I HEREBY CERTIFY, That I attended deceased from May 1 1916, to July 28 1916, that I last saw h... alive on July 20 1916, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Acute ulcerative endocarditis

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. H. Talbman M. D.

7/29 19 16 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence Ia. Boise & Lake

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery | DATE OF BURIAL: 7/30 1916

20. UNDERTAKER: Schreiber & Siedenfaden | ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOKS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14976
Registered No. 175

1. PLACE OF DEATH.
County of Ada
City of Boise.
(No. 1411 Franklin St.)
Registration District No. 2
Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Ann Wadsworth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. March 6 1827 (Month) (Day) (Year)

7. AGE: 89 Yrs. 4 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass

10. NAME OF FATHER: Hindley Davenport

11. BIRTHPLACE OF FATHER (State or Country): Rhode Island

12. MAIDEN NAME OF MOTHER: Elizabeth Booth

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Adolph Blitz
(Address) Boise, Idaho

15. Filed 7/17 1916
E. J. Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1916, to July 15 1916, that I last saw her alive on July 15 1916, and that death occured on the date stated above, at 11 a. M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) Yrs. — mos. 1 ds.

Contributory (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) Leo P. Kinnaya M. D.

July 17 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Minneapolis Minn. DATE OF BURIAL: Sept 1 1916

20. UNDERTAKER: Frey & Summers ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14077

Registered No. 172

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Caroline Elizth Hausen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH. April 19th 1912
(Month) (Day) (Year)

7. AGE 4 Yrs. 2 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF FATHER Arthur J. Hausen

11. BIRTHPLACE OF FATHER (State or Country) Minn

12. MAIDEN NAME OF MOTHER Mabel C. Everett

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur J. Hausen

(Address) 612 North 8. St.

15. Filed 7/17 1916

E. J. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 14 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1916, to July 14 1916, that I last saw h.er alive on July 14 1916, and that death occured on the date stated above, at 1145 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

.....(Duration) ..... Yrs. 1 mos. 14 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W S Peters M. D.

7-15 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Star Cemetery — DATE OF BURIAL July 17 1916

20. UNDERTAKER Christensen & Eidemiller — ADDRESS Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 11978
Registered No. 170

1. PLACE OF DEATH.

County of Ada

City of Boise.

Registration District No. 2

Primary Registration District No. 100 4

(No. 418 O'Farrell St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nellie R. Connell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan 22 1884
(Month) (Day) (Year)

7. AGE: 32 Yrs. 5 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Lewis E. Richardson

11. BIRTHPLACE OF FATHER (State or Country): Missouri.

12. MAIDEN NAME OF MOTHER: Emma Waldron.

13. BIRTHPLACE OF MOTHER (State or Country): Missouri.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Roy Connell.
(Address) 418 O'Farrell St.

15. Filed 7/11 1916

E. H. Cutter
Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 11 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1916, to July 11 1916, that I last saw h[illegible] alive on July 9 1916, and that death occured on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach

(Duration) ..... Yrs. [illegible] mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jas. L. Cluver M. D.
7/11 1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	July 12 1916
20. UNDERTAKER	ADDRESS
Frye & Summers Co.	Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 14979

Registered No. 169

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ernst Cramer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. May (Month) 23 (Day) 1833 (Year)

7. AGE: 83 Yrs. 1 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

9. BIRTHPLACE (State or Country): Frankfort Germany

10. NAME OF FATHER: Philip Cramer

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Louise Greighop

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. W. Johnson

(Address) 311 N. 5th St Boise Ida

15. Filed 7/11 1916

E. L. Paton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1916, to July 10 1916, that I last saw h[illegible] alive on July 10 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Valvular heart disease

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) R. E. Stuntz M. D.

July 6 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Hailey Idaho

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery | DATE OF BURIAL: July 12 1916

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 14980
Registered No. 168

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 110 East Fourth St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fannie J. Jenkins.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Sep (Month) 18 (Day) 1848 (Year)

7. AGE: 67 Yrs. 9 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John Bier.

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Bertha Innskeep.
(Address) Gooding Idaho.

15. Filed 7/10 1916
E. J. Cotton
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 10th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7th 1916, to July 9th 1916, that I last saw her alive on July 9 1916, and that death occured on the date stated above, at 2 a.m. M.

The CAUSE OF DEATH* was as follows: July 10/16
Meningitis from suppurative ear.

(Duration) [redacted] Yrs. 2 mos. — ds.
Contributory (Secondary) Palsy + necrosis of internal ear
(Duration 2 yrs. mos. ds.

(Signed) R. L. Mauney M. D.
July 10 1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding Idaho. DATE OF BURIAL: 191

20. UNDERTAKER: Frye & Summers ADDRESS: Boise Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 14981
Registered No. 167

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 410 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nuimuim Salish

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 1st (Day) 1891 (Year)

7. AGE: 25 Yrs. 7 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Syria

10. NAME OF FATHER: M. Toriye

11. BIRTHPLACE OF FATHER (State or Country): Syria

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Syria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H Babib
(Address) Pocatello

15. Filed 7/8 1916 E J Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1915, to July 7 1916, that I last saw her alive on July 7th 1916, and that death occured on the date stated above, at 5P M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) R E Sharp M. D.
July 8 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence: Boise

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 7/9 1916

20. UNDERTAKER: Schreiber & Hickenbottom — ADDRESS: Boise

Dr. Sharp

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24854

TELEPHONE 2086
OFFICE, 208 OVERLAND BLDG.

TELEPHONE 2087
RESIDENCE, 205 JEFFERSON ST

DR. R. E. SHURTZ

BOISE IDAHO Dec 28, 16

Dr Ralph Falk.

In regards the death Certificate in this case I understood Dr Williamson had treated Mrs Sallee for Tuberculosis from 1914 but by her statement it was 1915 therefore I think the certificate should be changed to read one year instead two years as I made it out at the time

R. E. Shurtz

Dr. L. S. Williamson
BOISE, IDAHO

To Whom it may Concern:

This Certifies that I was the attending physician in the family of Harry Salch Reading at 1601-N 9th St. from the year 1912. until about Sept 1915. Mrs Salch enjoyed reliuay health until after the birth of her son, born July 1914. I first discovered her to be tuberculous in Aug 1915.

Dec 27-16.

Respectfully
L. S. Williamson M.D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 14982

Registered No. 166

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 206 Jefferson St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Atkinson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 11 (Day) 1836 (Year)

7. AGE: 79 Yrs. 7 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)... Blacksmith

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Atkinson

11. BIRTHPLACE OF FATHER (State or Country) Not Obtained

12. MAIDEN NAME OF MOTHER Mrs. Green.

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. J. Atkinson
(Address) Boise, Idaho.

15. Filed 7/8 1916 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 1916, to July 1916, that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 1-9 M.

The CAUSE OF DEATH* was as follows:
Chronic nephritis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration ... yrs. ... mos. ... ds.

(Signed) [illegible] M. D.

19.... (Address) ...

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery | DATE OF BURIAL: July 10 1916

20. UNDERTAKER: Frey & Summers | ADDRESS: Boise Idaho

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 14983
Registered No. 165

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 525 S. 12 St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John McClellan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 11 1827 (Month) (Day) (Year)

7. AGE: 89 Yrs. 3 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John McClellan

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Amanda Red

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Lasha Taylor
(Address) 432 S-11 St.

15. Filed 7/8 1916
E. L. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 8 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1916, to July 5 1916, that I last saw h[illegible] alive on July 5 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Bright's [illegible]
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: July 9 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14984
Registered No. 163

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 State St.)

Registration District No. 8

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME [redacted] Rose Catan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1884 (Year)

7. AGE: 32 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER not Obtainable

11. BIRTHPLACE OF FATHER not Obtainable (State or Country)

12. MAIDEN NAME OF MOTHER not Obtainable

13. BIRTHPLACE OF MOTHER not Obtainable (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. M. Catan
(Address) 622 S 13th, Boise

15. Filed 7/5 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1916, to July 6 1916, that I last saw h[illegible] alive on July 5 1916, and that death occured on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:
Exhaustion following
hemorrhage into spinal
cord - 5 years standing
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) M. H. Saleeman M. D.
7/6 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 7 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

Dr. Tallmon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

(No. 418 Thatcher St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14985

Registered No. 1662

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

2. FULL NAME Margaret Johns

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write one word.): Widowed

6. DATE OF BIRTH. Nov. (Month) 24 (Day) 1837 (Year)

7. AGE 78 Yrs. 7 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana.

10. NAME OF FATHER: Jedediah Baldwin

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Mary Jerrett

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Warren S. Chipp
(Address) 418 Thatcher St. Boise Idaho

15. Filed 7/6 191 6

E. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 5th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13th 1916, to July 5th 1916, that I last saw h er alive on July 5th 1916, and that death occured on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:
Apoplexy - first stroke
June 13th 1916 - never
Recovered completely
(Duration) Yrs. mos. ds.
Contributory (Secondary) Arteria sclerosis
(Duration yrs. mos. ds.

(Signed) J. M. Taylor M. D.
July 6th 16 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burlington Oregon — DATE OF BURIAL: July 7 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

(No. St Lukes Hospital St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14986

Registered No. 161

1. PLACE OF DEATH.

County of Ada.

City of Boise.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leora Dial.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Jan (Day) 18 (Year) 1872

7. AGE: 43 Yrs. 5 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois.

10. NAME OF FATHER: William Dyer.

11. BIRTHPLACE OF FATHER (State or Country): Maine.

12. MAIDEN NAME OF MOTHER: Mary Reed.

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E E Dial

(Address) .....

15. Filed 7/4 191 6 E Pulton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3? (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1916, to July 3? 1916, that I last saw h.. alive on July 3? 1916, and that death occured on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:

Convulsions

presumable due to abscess or tumor on brain

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jas Boeckel M. D.

7-3 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE - (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	July 5 1916
20. UNDERTAKER	ADDRESS
Foy & Summers	Boise Ida

BYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 14987
Registered No. 160

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1917 Eastman St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clarence P. Reich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 16 (Day) 1874 (Year)

7. AGE: 31 Yrs. 8 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.: Lumber dealer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: F A Reich.

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Pearl W Weinberg

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mrs. C. P. Reich
(Address): Boise - Idaho

15. Filed 6/30 1916 E S Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 28" (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 20" 1916, to June 28" 1916, that I last saw him alive on June 28 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Renal Insufficiency
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H B Smith M. D.
6/30 1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Iowa | DATE OF BURIAL: July 2 1916

20. UNDERTAKER: Fry & Summers | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 14988
Registered No. 159

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rufus Morton Gaskill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 1 (Day) 1876 (Year)

7. AGE: 38 Yrs. 6 Mos. ... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Hiram Gaskill

11. BIRTHPLACE OF FATHER (State or Country): Ann.

12. MAIDEN NAME OF MOTHER: Not attainable

13. BIRTHPLACE OF MOTHER (State or Country): Ann.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs R M Gaskill
(Address) Boise, Idaho

15. Filed 7/1 191 6 E. V. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-27 1916, to 6-30 1916, that I last saw h[illegible] alive on June 30 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Jaundice
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration ... yrs. ... mos. ... ds.

(Signed) ... M. D.
7-1 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 7/2 1916

20. UNDERTAKER: Schreiber & Hedenstedt — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14989

Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada.

City of Barber.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2004

(No. ..... St.)

2. FULL NAME Mary E. Pettit.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed. (~~Wife of~~ ~~Widow~~.)

6. DATE OF BIRTH: Apr 15 (Month) (Day) 1839 (Year)

7. AGE: 77 Yrs. 2 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois.

10. NAME OF FATHER: Miller.

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable.

12. MAIDEN NAME OF MOTHER: Foyle.

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. K. Pettit

(Address) Barber Idaho

15. Filed July 1 1916. E. F. Foster Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 30 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1916, to June 24 1916, that I last saw her alive on June 24 1916 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Myocarditis

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Organic heart disease

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ray Hall M. D.

July 1 1916 (Address) Barber

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: July 2 1916

20. UNDERTAKER: Fry & Summers Co. — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14990
Registered No. 39

Registration District No. 8
Primary Registration District No. 2004

1. PLACE OF DEATH.
County of Boise
City of Near Centerville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Gemmeke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 16 (Day) 1880 (Year)

7. AGE: 36 Yrs. 3 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: George Gemmeke

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Louis Gemmeke
(Address) Barber Idaho

15. Filed July 10 1916 — E. H. Eaton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1916 to July 9 1916, that I last saw h alive on July 9 1916, and that death occured on the date stated above, at 8.30 M.

The CAUSE OF DEATH* was as follows:
Accidently Killed by falling log
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers M. D.
July 10 1916 (Address) Boise Idaho County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL: July 12 1916

20. UNDERTAKER: Frey & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14991

Registered No. 40

1. PLACE OF DEATH.

County of Ada

City of

(No. near Summit St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Bernice DeBord

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 3 (Day) 1896 (Year)

7. AGE: 19 Yrs. 11 Mos. 14 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: D. T. Gay

11. BIRTHPLACE OF FATHER (State or Country): Am.

12. MAIDEN NAME OF MOTHER: Ella Richardson

13. BIRTHPLACE OF MOTHER (State or Country): Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lanys DeBord

(Address) Eheaville Ave

15. Filed July 18 1916

E. J. Eaton
Local Registrar

SYMS-YORK CO., PTRS. & SORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1916, to May 27 1916, that I last saw h.. alive on May 27 1916, and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary)

.....(Duration .....yrs. .....mos. .....ds.

(Signed) Jos R. Richardson M. D.

7/17 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Richfield Ida

DATE OF BURIAL: July 19 1916

20. UNDERTAKER: Schreiber & Hidenbrand

ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14992

Registered No. 71

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. State Penitentiary St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George A Burrell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1855 (Year)

7. AGE: 61 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cook 13 years

(b) General nature of industry, business, or establishment in which employed (or employer): Service in U.S. Cavalry 9th 10th,

9. BIRTHPLACE (State or Country): Jamaica W.I.

10. NAME OF FATHER: W H Burrell

11. BIRTHPLACE OF FATHER (State or Country): Jamaica W.I.

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Jamaica W.I.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Snook

(Address) Boise, Idaho

15. Filed July 22 1916 E H Cole Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 1915, to July 19 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 9-45a M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) Soldiers Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pen. Cemetery — DATE OF BURIAL: 7/22/1916

20. UNDERTAKER: Silvertson & Redemann — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WITH UNFADING INK—THIS IS A PERMANENT RECORD. should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14093

Registered No. 43

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Eagle

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 8004

(No. Ada County St.)

2. FULL NAME Robert E. Sells

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Single

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): White

6. DATE OF BIRTH. June (Month) 24 (Day) 1890 (Year)

7. AGE: 26 Yrs. 1 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Rancher

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Shannon Co. Mo.

10. NAME OF FATHER J. H. Sells

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Martha Sparks

13. BIRTHPLACE OF MOTHER (State or Country) Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) J. H. Sells Eagle Ida

15. Filed July 29 1916

E. F. Clark
Local Registrar

BYRD-YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 29th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27 1916, to July 29 1916, that I last saw he alive on July 27 1916, and that death occured on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Tuberculous bladder.

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R E Sells M. D.

July 29 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Ada County, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery | DATE OF BURIAL: 7/30 1916

20. UNDERTAKER: Schreiber & Siderfaden | ADDRESS: Boise, Ida

County of Ada

City of Meridian Id

Registration District No. 11

Primary Registration District No. 2003

(No. ..... St.)

BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

File No. 14994

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Elsie May Vass.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed or Divorced. (Write the Word): Married

6. DATE OF BIRTH. April (Month) 2 (Day) 1876 ~~191~~ (Year)

7. AGE. 40 Yrs. 3 Mos. 27 ds.

IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION.
(a) Trade, profession or partcular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE. (State or Country) Iowa

10. NAME OF FATHER: David Frost

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charlotte ann Vass.
(Address) Meridian, Idaho.

15. Filed July 31 1916 C. L. Dutton Local Registrar.

Place Where Remains are to be Sent. Garwin, Iowa.

Date of Shipment 7/31 1916

SHIPPING UNDERTAKER
ADDRESS Meridian Idaho. Firm Name Wormater

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1916, to July 29 1916; that I last saw h.. alive on July 29 1916, and that death occurred on the date stated above, at 6.20 M.

The CAUSE OF DEATH was as follows:

Septicaemia
Carcinoma

(Duration) ..... Years ..... mos. 3 5 ds.

Contributory (Secondary) Miscarriage

(Duration) ..... Years ..... mos. ..... ds.

(Signed) W. F. Neal M. D.

July 31 1916 (Address) Meridian Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Sucidial or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days
In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Garwin Iowa — Date of Burial ..... 191..

20. UNDERTAKER — Address

This is an exact COPY of the official certificate filed at place of death.

County of Ada. Registration District No.

City of Meridian Idaho Primary Registration District No. 2003.

(No. St.)

BUREAU OF VITAL STATISTICS

File No. 14995

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jackson E. Freys

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed or Divorced (Write Word)
Male	White	Married

6. DATE OF BIRTH. June (Month) 24 (Day) 1878 (Year)

7. AGE. 38 Yrs. 11 Mos. 25 ds. IF LESS than 1 day, how many.....hrs. or .....min.?

8. OCCUPATION.
(a) Trade, profession or partcular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE. (State or Country) Pennsylvania

10. NAME OF FATHER Jackson Freys

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Mary Colvert

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lula Freys
(Address) Meridian Idaho

15. Filed ..... 191.... Local Registrar.

Place Where Remains are to be Sent. Wakefield Kansas. | Date of Shipment June 17 1916

SHIPPING UNDERTAKER

ADDRESS W.S. Mateer Meridian Ida. Firm Name

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1916, to June 15 1916; that I last saw him alive on June 15 1916, and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH was as follows:

Acute Peritonitis

(Duration) ? Years ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Years ..... mos. ? ds.

(Signed) W.F. Neal M. D.

June 16 1916 (Address) Meridian Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Sucidial or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)
At place ..... In the
of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted if not at place of death

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Wakefield Kansas. | Date of Burial .....191....

20. UNDERTAKER | Address

The information on this certificate is an exact COPY of the official certificate filed at place of death.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14996

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of .....

(No. ....., ... St.)

Registration District No. 11

Primary Registration District No. 2003

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elizabeth Amack

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 5 (Day) 1856 (Year)

7. AGE: 59 Yrs. 11 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Henry Young

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Sarah Ellis

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. E. Amack

(Address) Nampa R.D.2.

15. Filed July-4- 1916 C. L. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 4th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March — 1916, to July-14 1916, that I last saw her alive on July 1st 1916 and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis — —
Paralysis following
apoplexy 3 years ago.

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Sutton M. D.

19..... (Address) Meridian Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian — DATE OF BURIAL: 7-6 1916

20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 11

Primary Registration District No. 2003.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. 14998

1. PLACE OF DEATH.

County of Ada

City of

(No. east end of Meridian St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Pilgrim

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 26 (Day) 1916 (Year)

7. AGE: ....Yrs....Mos. 5 ds.

IF LESS than 1 day how many ....hrs. or ....min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada Co.

10. NAME OF FATHER: L. G. Pilgrim

11. BIRTHPLACE OF FATHER (State or Country): Ore.

12. MAIDEN NAME OF MOTHER: Mamie Crawford

13. BIRTHPLACE OF MOTHER (State or Country): Ada Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. L. Crawford

(Address)

15. Filed June 1st 1916

E. L. Sutton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1916, to June 1st 1916, that I last saw her alive on May 31st 1916, and that death occured on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Malnourlopement

Opening of Oesophagus into Trachea & Nooperning into Stomach

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

6/1 (Signed) E. L. Sutton M. D.

1916 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: June 1 1916

20. UNDERTAKER: Schreiber & Hidenfoden — ADDRESS: Boise

SYMS - YORK CO., PTRS. & BOKS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

County of Idaho

Primary Registration District No. 2003

File No. 14999

City of Whitebird (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Dewit Daley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
male	white	

6. DATE OF BIRTH: January (Month) 13th (Day) 1850 (Year)

7. AGE: 66 yrs. 4 mos. 16 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Joseph Daley

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Pernilla

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Millard Daley
(Address) .....

15. Filed June 2 1916 C. L. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916, to May 29 1916, that I last saw h. in alive on May 29 1916 and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia
Following Lo Grippe

(Duration) ..... yrs. 5 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. 2 mos. ½ ds.

(Signed) W. A. Foskett M. D.

May 29 1916. (Address) Whitebird Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Meridian	June 2 1916
20. UNDERTAKER	ADDRESS
Hanson	Grangeville Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO. PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIA should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Registration District No. .....

County of Ada

City of Meridian

Primary Registration District No. 2003

(No. 2 Miles N. W. of Meridian St.)

File No. 15000

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Eliza Holman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 15½ (Day) 1852 (Year)

7. AGE: 54 Yrs. — Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ills.

10. NAME OF FATHER J. C. Shackelford

11. BIRTHPLACE OF FATHER Tenn

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D W Holman

(Address) Meridian Idaho

15.

Filed June-10 1916

C. L. Sutton Local Registrar

Sutton

SYMS - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9½ (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1916, to June 9th 1916, that I last saw her alive on June 9th 1916, and that death occured on the date stated above, at 8 M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis—
following Streptococcus
infection of throat.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Sutton ——— M. D.

19..... (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Ada County, Ida.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 6/11 1916

20. UNDERTAKER: Schreiber & Siedenfaden | ADDRESS: Boise.

DISINTERMENT PERMIT

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of [illegible] now lying buried in Morris Hill Cemetery, in the City or Town of [illegible] Boise County of Ada State of Idaho, who died on the 9 day of June, 19[illegible]; Aged 54 years ___ months ___ days, the cause of death being heart disease and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever; or yellow fever as shown by the certificate of death of said deceased, given by

C. L. Dutton attending Physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private conveyance
private or railway conveyance
to Morris Hill Cemetery in the City or Town of Boise County of Ada State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of Ada it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the Department of Public Health governing the Transportation of Corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the Department of Public Health at Boise, Idaho,

permit issued to: this 25 day of May, A.D. 19[illegible].

Mabel H Leeper
Deputy Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of Ada State of Idaho, this 26 day of May 1951.

H. Fred Baldwin
Health Officer

Form DPH-48019

Form V. S. No. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11

Primary Registration District No. 2003

File No. 15001

Registered No. .....

1. PLACE OF DEATH.
County of Ada
City of Meridian
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Johan James Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept 27 1858 (Month) (Day) (Year)

7. AGE: 57 Yrs. 7 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Banker-Farmer & Stockman.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Hancock Co Tenn.

10. NAME OF FATHER Calvin C. Jones.

11. BIRTHPLACE OF FATHER (State or Country) Lee Co Virginia

12. MAIDEN NAME OF MOTHER Sarah Kyle.

13. BIRTHPLACE OF MOTHER (State or Country) Hawkins Co Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jessie L. Davidson
(Address) Meridian Idaho.

15. Filed May-18- 1916
C. L. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 1916, to May 17 1916, that I last saw h[illegible] alive on May 17 1916, and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
(Chronic Valvular)
(Duration) Yrs. 2 mos. ds.
Contributory (Secondary) Acute Gastritis & Sloughing Throat
(Duration) yrs. 2 mos. 15 ds.
(Signed) Halbert F. Reed M. D.
May 17 1916 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: May 19 1916

20. UNDERTAKER: W. S. Nater — ADDRESS: Meridian Id.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STEAM - WORK CO., PRINTERS & STAM. 24658

Fo[redacted] 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2077
File No. 15002
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Burley
If death occurs away from usual residence, give facts called for under special information.
(No. , St.)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gilphia Ellen Wilkinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH: Jan (Month) 26th (Day) 1842 (Year)

7. AGE: 74 yrs. 5 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jefferson Co Iowa

10. NAME OF FATHER: John Davis

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Bethany Jost

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Albert Winters
(Address): Burley Ida

15.
Filed 7-10 1916 J. H. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1916, to July 9 1916, that I last saw her alive on July 9 1916, and that death occurred on the date stated above, at 11:15 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) yrs. mos. 9 ds.
Contributory (Secondary) Chronic Interstitial Nephritis
(Duration) 4 years (?) mos. ds.
(Signed) J. H. Hutchinson M. D.
7/10 1916 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Union Ore
DATE OF BURIAL: 191

20. UNDERTAKER: Homer B Evans
ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2077
File No. 15003
Registered No. .....

1. PLACE OF DEATH.

County of .....
City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vida J Zimmerman,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Sept. (Month) 10 (Day) 1888 (Year)

7. AGE: 27 Yrs. ..... Mos. 9 ..... ds. 26
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Grinnell Iowa

10. NAME OF FATHER C. C. Rouse.

11. BIRTHPLACE OF FATHER (State or Country) Kent Ohio.

12. MAIDEN NAME OF MOTHER Charlotte Hughes.

13. BIRTHPLACE OF MOTHER (State or Country) Clayton Co Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. C. Rouse
(Address) Nampa Idaho

15.
Filed 7-7- 1916 J. Mumby Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July 6 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1916, to July 6 1916, that I last saw her alive on July 6 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Puerperal septicemia following self induced abortion.

..... (Duration) ..... Yrs. ..... mos. 43 ds.

Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Wetherbee M. D.
7/6 1916 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl Ida — DATE OF BURIAL: July 8 1916

20. UNDERTAKER: Homer B Evans — ADDRESS: Buhl Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Fish Haven
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

File No. 15004
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Venice Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May 4 1903 (Month) (Day) (Year)

7. AGE: 13 yrs. 3 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hyde Park, Utah

10. NAME OF FATHER: Thomas Nelson

11. BIRTHPLACE OF FATHER (State or Country): Logan, Utah

12. MAIDEN NAME OF MOTHER: Clara Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Hyde Park

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Nelson
(Address) Hyde Park

15. Filed Aug 14 1916 John Mattson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1916 to Aug 11 1916, that I last saw h[er] alive on Aug 11 1916, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Peritonitis

(Duration) — yrs. — mos. 8 ds.
Contributory (Secondary): Appendicitis
(Duration) — yrs. — mos. 3 ds.

(Signed) W. C. Budge M. D.
19 (Address) Fog and Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence. Hyde Park

19. PLACE OF BURIAL OR REMOVAL: Hyde Park — DATE OF BURIAL: Aug 13 1916

20. UNDERTAKER: C. A. Lundquist — ADDRESS: Logan

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 47
Primary Registration District No. 21 24
(No. ..... St.)

File No. 15005
Registered No. 9

1. PLACE OF DEATH.
County of Lewis
City of Nezperce R F D

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Sauter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. July (Month) 16 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 1/3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: baby.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Nezperce R F D.

10. NAME OF FATHER Edwin Bruce Sauter.

11. BIRTHPLACE OF FATHER (State or Country) Bear River Idaho.

12. MAIDEN NAME OF MOTHER Eulia Slack

13. BIRTHPLACE OF MOTHER (State or Country) Nezperce Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed Aug. 9 1916
J. Jones
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1916, to July 17 1916.; that I last saw h[illegible] alive on July 17 1916., and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Premature child. Development = 6½ months intra-uterine.
(Duration) ..... Yrs. ..... mos. 1/3 ds.
Contributory (Secondary) —
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) R. E. Dunlap M. D.
8/7 1916 (Address) Nezperce, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL ..... 191.....

20. UNDERTAKER — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. 15908
Registered No. .....

1. PLACE OF DEATH.

County of Bannock
City of St Maries

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Winifred L. Brayden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 10 (Day) 1914 (Year)

7. AGE: — Yrs. — Mos. 2 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Edward A Brayden

11. BIRTHPLACE OF FATHER (State or Country) Ills.

12. MAIDEN NAME OF MOTHER Eva L Carpenter

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward A Brayden
(Address) Avery

15. Filed July 31 1916.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1916, to July 30 1916, that I last saw h[illegible] alive on July 30 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Premature birth & debility.

(Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Cornwell M. D.
7/31 1916 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: July 1 1916

20. UNDERTAKER: H E Smith — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benewah — Registration District No. 32

City of St Maries — Primary Registration District No. 2059

(No. ..... St.)

File No. 15010

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mike Sofi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1891 (Year)

7. AGE: 24 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Section Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: D. K.

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D C Cornwall

(Address) St Maries

15.

Filed 7/27 1914 — H E Smith, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1916, to July 21 1916, that I last saw h[illegible] alive on July 21 1916, and that death occured on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Appendicitis + Peritonitis

(Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Cornwall M. D.

7/27 1916 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: July 23 1916

20. UNDERTAKER: H E Smith — ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 15011
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Benewah
City of St Maries

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily H. Germain

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fm

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 26 (Day) 1882 (Year)

7. AGE: 34 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: Wm Harding

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Augusta Ramthun

13. BIRTHPLACE OF MOTHER (State or Country): Germ

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. L. Germain
(Address) St Maries

15. Filed July 31 1916 H. E. Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1916, to July 29 1916, that I last saw her alive on July 29 1916, and that death occured on the date stated above, at 4a M.

The CAUSE OF DEATH* was as follows: —
General Septicaemia

(Duration) 2 Yrs. 4 mos. 3 ds.
Contributory (Secondary): Premature Labor
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Owen O'Flaherty M. D.
7/31/1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: July 31 1916

20. UNDERTAKER: H. E. Hunt — ADDRESS: St Maries

STAR - YORK CO., PTRS. & SONS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Benewah

City of St. Maries

Registration District No. 32

Primary Registration District No. 2049

(No. .... St.)

File No. 15012

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unknown Baby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Don't know

6. DATE OF BIRTH. Don't know - (Month) (Day) 1 (Year)

7. AGE: About 40 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Don't know -

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. J. Kinsolving

(Address) St Maries, Ida.

15.

Filed July 31 1916

H E Hunt
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Don't know - Found - July (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental drowning in St Joe, river -

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Kinsolving Co. M. D.

7/31 1916 (Address) St Maries Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: July 31 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15013

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Benewah.

City of St. Maries.

(No. ....., ... St.)

Registration District No. 32

Primary Registration District No. 2049

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME C. Bollmon.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWER OR DIVORCED. (Write the word.): D.T.

6. DATE OF BIRTH. Dont know. (Month) (Day) 1 (Year)

7. AGE About 46 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer in woods.

(b) General nature of industry, business, or establishment in which employed (or employer)..... Logging.

9. BIRTHPLACE (State or Country) Dont know.

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthy Douglass.

(Address) Fernwood Idaho.

15.

Filed July 9 1916. H Eastmt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 1 (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Crushed leg & foot, by being Caught under log Loader

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. Kinnaburg Coroner M. D.

7/2 1916 (Address) St Maries, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: July 7 1916.

20. UNDERTAKER: H Eastmt — ADDRESS: St Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15014
Registered No. .....

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Benewah
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown - body found floating in river

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Dont know -
6. DATE OF BIRTH. Dont know - (Month) (Day) 1 (Year)
7. AGE: about 35 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Dont Know only
(b) General nature of industry, business, or establishment in which employed (or employer)..... Common Laborer Clothes
9. BIRTHPLACE (State or Country) Foreigner born - Spoke to be Finlander
10. NAME OF FATHER Dont know -
11. BIRTHPLACE OF FATHER (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (State or Country) " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. J. Kinnebrew Coroner
(Address) St. Maries
15. Filed July 23 1916 H E Hart Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dont know - found floating in river. July (Month) 23 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidental drowning in St Joe river, body so decomposed nothing could be identified, but he is supposed to be Amos. Finlander
Contributory (Secondary) Drown Along river bank
(Duration) July - 1916. yrs. ..... mos. ..... ds.
(Signed) C. J. Kinnebrew Coroner M. D.
July 24/1916 (Address) St Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: July 24 1916
20. UNDERTAKER: H E Hart — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15015

Registered No. ____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Benewah

City of St Maries

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32

Primary Registration District No. 2049

(No. ____ ____ St.)

2. FULL NAME Nic Katzee

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dont Know. (Month) (Day) (Year)

7. AGE: about 38 Yrs. ____ Mos. ____ ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Dont Know

10. NAME OF FATHER: ″ ″

11. BIRTHPLACE OF FATHER (State or Country): ″ ″

12. MAIDEN NAME OF MOTHER: ″ ″

13. BIRTHPLACE OF MOTHER (State or Country): ″ ″

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ____

(Address) ____

15. Filed July 26 1916

H E Arnst
Local Registrar

SYMS-YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1916, to July 26 1916, that I last saw him alive on July 26 1916, and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Shock following severe hemorrhage due to injury from fire & severe exposure & alcoholism

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) L D Platt M. D.

July 26 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: St Maries

DATE OF BURIAL: July 28 1916

20. UNDERTAKER: H E Arnst

ADDRESS: St Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15016
Registered No. .....

1. PLACE OF DEATH.
County of Bannock
City of Santee
(No. ....., ... St.)
Registration District No. 32
Primary Registration District No. 2049
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John H Rensfro.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Nov. (Month) 2 (Day) 1871 (Year)

7. AGE
44 Yrs. 8 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Mo.

10. NAME OF FATHER: Silas Rensfro.

11. BIRTHPLACE OF FATHER
(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER: Sarah J Mahurin

13. BIRTHPLACE OF MOTHER
(State or Country) Kentuck

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs John H Rensfro
(Address) Santee

15.
Filed July 26 1916
H E Strunk
Local Registrar

SYMS – YORK CO., PTRS. & ENGS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1916, to July 23 1916, that I last saw h[illegible] alive on July 23 1916, and that death occured on the date stated above, at 11 30 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemmorhage
.....
.....
.....(Duration) 2 Yrs. mos. 2 ds.
Contributory (Secondary) Following cerebral effusion
.....(Duration ..... yrs. 0 mos. ..... ds.

(Signed) Owen D Clapp M. D.
July 26 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Santee. DATE OF BURIAL: July 26 1916

20. UNDERTAKER: H E Strunk ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-2 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 15017
Registered No. .....

1. PLACE OF DEATH.
County of Bonneville
City of St Maries
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles N. Babin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Don't Know.
6. DATE OF BIRTH. Don't Know. (Month) (Day) (Year)
7. AGE 40 Yrs. ..... Mos. ..... ds. Years About. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Timbermen
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) —
10. NAME OF FATHER —
11. BIRTHPLACE OF FATHER (State or Country) —
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (State or Country) —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. Krueselberg M.D.
(Address) St Maries
15. Filed July 16 1916 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 15 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 1-0 M.
The CAUSE OF DEATH* was as follows:
Gun Shot Wound thru hip & Abdominal Cavity
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. Krueselberg Coroner M. D.
7/16 1916 (Address) St Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: July 17 1916
20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

BYNUM-YORK CO., PTGS. & BDRS. 24854

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15018

Registered No. .....

Registration District No. 32

Primary Registration District No. 2049

1. PLACE OF DEATH.

County of Shoshone

City of Wardner (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Beef Mondoy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Don't know

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: About 50 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer)... logging on River

9. BIRTHPLACE (State or Country) Don't Know

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Colgan

(Address) St Maries

15. Filed July 15 1914.

H E Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental drowning while driving logs in river

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C A Kinnaslining Coron M. D.

7/15 1914 (Address) St Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries DATE OF BURIAL: July 15 1914

20. UNDERTAKER: H E Smith ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. - BOBS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 32

County of Bonneville

Primary Registration District No. 2049

City of St Maries

File No. 15019

(No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas St Peter

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Dont Know

6. DATE OF BIRTH

..... (Month) ..... (Day) 1837 (Year)

7. AGE

79 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Lumberman

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Dont Know

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) DE Cornwall

(Address) St Maries

15. Filed July 14 1916 H Eastman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1916, to July 13 1916, that I last saw h im alive on July 13 1916 and that death occurred on the date stated above, at 14 M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

..... (Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary) Fracture leg.

..... (Duration) ..... yrs. ..... mos. 8 ds.

(Signed) DE Cornwall M. D.

7/14 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. 6 days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL St Maries — DATE OF BURIAL July 14 1916

20. UNDERTAKER H Eastman — ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15020
Registered No. .....

1. PLACE OF DEATH.

Registration District No. 92
Primary Registration District No. 2049
(No. ....., ... St.)

County of Benewah
City of St Maries

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elijah R Hawkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan. (Month) 21 (Day) 1894 (Year)

7. AGE: 22 Yrs. 5 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Jameson Hawkins

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Julia V. Offutt

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. B. Hawkins
(Address) Pasco, Washington

15. Filed July 13 1916. H E Hamph Local Registrar

SYMS-YORK CO., PTRS. DENVER. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Accidental Drowning -
Drowned in Swimming in St Maries river, probably Cramped & sank.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O Kirschbaum Coroner M. D.
July 13 1916 (Address) St Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry — DATE OF BURIAL ..... 191...

20. UNDERTAKER: H E Hamph — ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 15021
Registered No. .....

1. PLACE OF DEATH.
County of Bonneville
City of near St. Joe
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sam Miskiewicz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Perhaps Bulgarian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): don't Remember

6. DATE OF BIRTH: — — 1 (Month) (Day) (Year)

7. AGE: About 22 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country): Don't Know

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas R Schulte
(Address) St Maries

15. Filed July 10 1916 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Found July 9, 1916
Perhaps April 1st 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Drowning
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Chas. R. Schulte M. D.
7/10 1916 (Address) St. Maries (acting Coroner)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: July 10 1916

20. UNDERTAKER: H E Hunk — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS., BOSS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2049
(No. ..... St.)

File No. 15022
Registered No. .....

1. PLACE OF DEATH.
County of Benewah
City of St Maries

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Miss Tealia L Way

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan 17 (Month) 17 (Day) 1887 (Year)

7. AGE: 26 Yrs. ..... Mos. 6 ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Barryville Ark

10. NAME OF FATHER: D C Way.

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Mary C. Vess.

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Mary C Way.

15. Filed July 3 1916 H E Hamp Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1913, to July 1 1916, that I last saw her alive on July 1 1916, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Tuberculer Laryngitis
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pulmonary Tuberculosis
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Carey D Clark M. D.
July 1 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rockford Wash. DATE OF BURIAL: July 3 1916

20. UNDERTAKER: H E Hamp ADDRESS: St Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 97
Primary Registration District No. 2174
File No. 15023
Registered No. .....

1. PLACE OF DEATH.
County of Nez Perce
City of Lapwai
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sanford Bramlett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. February (Month) fourth (Day) 1828 (Year)

7. AGE: 88 Yrs. 5 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Tennessee Obion Co.

10. NAME OF FATHER: Art Kinnon

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hazel Musgrave Smith
(Address) Lapwai, Idaho

15. Filed July 26 1916 William O. Hobel, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26 1916, to July 26 1916, that I last saw h.. alive on July 26 1916, and that death occured on the date stated above, at 8.00 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) ..... Yrs. 1 mos. - ds.
Contributory (Secondary): Arteriosclerosis
(Duration) ..... yrs. - mos. ..... ds.

(Signed) William O. Hobel M. D.
July 26 1916 (Address) Lapwai - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Waitsburg Wash. DATE OF BURIAL: July 28 1916

20. UNDERTAKER: W B Williamson ADDRESS: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. ..... , ... St.)

File No. 15024
Registered No. 39

1. PLACE OF DEATH.

County of Canyon
City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Hannah S. Ramsey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec (Month) 23 (Day) 1858 (Year)

7. AGE: 57 Yrs. 7 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: John Gotchall

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Anna Stoner

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J B Ramsey
(Address) Caldwell, Idaho

15. Filed 8-5-1916 John S. Meyer Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1916, to Aug 3 1916, that I last saw h.r alive on Aug 2 1916, and that death occured on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Gallbladder

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J M Cole M. D.

8/4 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Aug 6 1916

20. UNDERTAKER: Peckham Care Co. — ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ....., ... St.)

File No. 15025
Registered No. 58

1. PLACE OF DEATH.
County of Canyon
City of Caldwell.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howard Nelson Fritts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 27 (Day) 1908 (Year)

7. AGE: 7 Yrs. 8 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Stockton Mo

10. NAME OF FATHER Carrolle Earl Fritts

11. BIRTHPLACE OF FATHER (State or Country) Stockton Mo

12. MAIDEN NAME OF MOTHER Mary L- adams

13. BIRTHPLACE OF MOTHER (State or Country) Stockton Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs B H Rice
(Address) Caldwell Ida

15.
Filed 7-30- 1916
John S. Meyer
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 25th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Drowning
Drowned while in bathing
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) A A Farris Coroner C.D.
7/25 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 7-30 1916

20. UNDERTAKER: W. C. Dyer
ADDRESS: Caldwell Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 15026
Registered No. 57

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William H McKinley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Sept (Month) 30 (Day) 1852 (Year)

7. AGE: 63 Yrs. 9 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... rancher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio.

10. NAME OF FATHER William McKinley

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Margaret Specht

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. M. E. McKinley
(Address) Notus, Idaho

15. Filed July 21st 1916
John D. Meyer
Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 30 1915, to July 19 1916, that I last saw h[illegible] alive on July 16 1916, and that death occured on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation and Mitral insufficiency
(Duration) / Yrs. mos. ds.
Contributory (Secondary) Nephritis
Duration 2 yrs. mos. ds.

(Signed) C. M. Tracy M. D.
July 21 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: July 24 1916

20. UNDERTAKER: Peckham Care Co ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 15027
Registered No. 56

1. PLACE OF DEATH.

County of Gem Co. Ida.
City of near Banks
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Crockette Clinton Bales.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. December (Month) 10 (Day) 1856 (Year)

7. AGE: 59 Yrs. 7 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher & stockman
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hancock County Tenn.

10. NAME OF FATHER: Johnathan Bales

11. BIRTHPLACE OF FATHER (State or Country): Hancock County

12. MAIDEN NAME OF MOTHER: Sarah C. Crockette

13. BIRTHPLACE OF MOTHER (State or Country): ~~Hancock Tenn~~ Gibson station Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. T. Bales
(Address) Caldwell Idaho

15.
Filed July 16 1916
John D. Meyer
Local Registrar

BYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Heart Disease
Dropped Dead
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. A. Faris acting Coroner for Gem Co. M. D.
(Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: July 16 1916

20. UNDERTAKER: W. C. Dyer — ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 15028
Registered No. 55

1. PLACE OF DEATH.
County of Canyon
City of Caldwell.
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Etta. Shipley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. September 4 (Month) (Day) 1884 (Year)

7. AGE: 31 Yrs. 10 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canyon Co. Idaho

10. NAME OF FATHER J. S. Froman

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER S. Keeney

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. R. Shipley
(Address) Caldwell. Idaho.

15. Filed July 12 1916 John S. Meyer Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1915, to Sept 10 1916, that I last saw h[illegible] alive on Sept 10 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis.
Pulmonis and mesenteric Chronic
Lesions. No Treatment M.D. for 4 Yrs.
(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Porter M. D.
7/11 1916 (Address) Coroners Office

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 7/13 1916

20. UNDERTAKER: W. E. Dyer
ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15029

Registered No. 54

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James G. Kinkaid

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Jan. (Month) 10 (Day) 1833 (Year)

7. AGE: 83 Yrs. 6 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Joseph Kinkaid

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Sarah Glenn

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dirk Kinkaid

(Address) Ronan Montana

15.

Filed July 12 1916

John L. Meyer
Local Registrar

BYRNS - YORK CO., PTRS. & STNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1916, to July 10 1916, that I last saw h[illegible]m alive on July 10 1916 and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Paralytic Stroke - Arteriosclerosis - old age

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible], M. D.

7/11 1916 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 7-12-1916

20. UNDERTAKER: W. G. Dyer — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-15

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. ....., ... St.)

File No. 15030
Registered No. 53

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lawrence C. Soward

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 14 (Day) 1901 (Year)

7. AGE: 14 Yrs. 9 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Henry E. Soward

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Mary C. Vermillion

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henery E. Soward
(Address) Caldwell, Ida

15. Filed July 10 1916 at Haines, Ore.
John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191—, to — 191—, that I last saw h— alive on — — 191—, and that death occured on the date stated above, at 3-20 P.M.

The CAUSE OF DEATH* was as follows:
Accidental Drowning
Near Railroad bridge crossing
Boise River
— (Duration) — Yrs. — mos. — ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) Geo W Stevens Acting Coroner
7-9 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Haines Oregon
DATE OF BURIAL: 7/10 1916

20. UNDERTAKER: W. C. Dyer
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRD - YORK CO., PTRS. & STNRS. 94652

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 15032
Registered No. 217

1. PLACE OF DEATH.
County of Canyon
City of Payette
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Vernon Walker
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 12 (Day) 1901 (Year)

7. AGE: 14 yrs. 7 mos. — ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thos Walker

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Isabel Cramer

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos Walker
(Address)

15. Filed July 13 1916 J.C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1916, to July 12 1916
that I last saw h[illegible] alive on July 12 1916
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Inspiration pneumonia
abcess and gangrene
of right lung
(Duration) ....yrs. ....mos. ....ds.

Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) J.C. Woodward M. D.
7/13 1916 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Riverside | DATE OF BURIAL: July 13 1916

20. UNDERTAKER: D. N. Cadair | ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. -1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15033

Registered No. 28

1. PLACE OF DEATH.

County of Washington

City of .....

(No. ....., ... St.)

Registration District No. 4

Primary Registration District No. 1008

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Franklin Noyer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.

Feb. (Month) 3rd (Day) 1869 (Year)

7. AGE

Yrs. 54 Mos. 5 ds. 9

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE

(State or Country) Monroe Co. Ohio

10. NAME OF FATHER William Noyer

11. BIRTHPLACE OF FATHER

(State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Elisabeth Stack

13. BIRTHPLACE OF MOTHER

(State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lenora D Noyer

(Address) Weiser Idaho R.F.D 3.

15.

Filed July 13th 1916 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1916, to June 18 1916, that I last saw him alive on June 17 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H B Cotron MD

7/13 1916. (Address) Payette Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Payette Idaho — DATE OF BURIAL July 15 1916

20. UNDERTAKER Glenn C Landon — ADDRESS Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & STRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 15034
Registered No. 1

1. PLACE OF DEATH.
County of Washington
City of Weiser
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elijah Werts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Mar. (Month) 4 (Day) 1849 (Year)

7. AGE: 95 Yrs. 4 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: ———

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: ———

13. BIRTHPLACE OF MOTHER (State or Country): W. Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chester G. Werts
(Address) Weiser, Idaho

15. Filed 7-8 1916 W. P. Hamilton Local Registrar

BYNS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1916, to July 6 1916, that I last saw h. in alive on July 6 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Brights Disease

(Duration) many Yrs. mos. ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) G. W. Naterhaus M. D.
7/7 1916 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho — DATE OF BURIAL: July 6 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
(No. ..... St.)

File No. 15035
Registered No. 2

1. PLACE OF DEATH.
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah E. Ryan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. May (Month) 10 (Day) 1 (Year)

7. AGE: 65 Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: John Wormock

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Mary Manley

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs H. S. Robinson
(Address) Mineral Ida

15. Filed July 13th 1916 — W. R. Hamilton, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1916, to July 12th 1916, that I last saw her alive on July 12th 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia of Bilateral
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) W. R. Hamilton M. D.
7/13/1916 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: 7/13 1916

20. UNDERTAKER: Northam & McCoy — ADDRESS: Weiser

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 86

Primary Registration District No. 2112

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15036

Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME DeEsta Byington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feby (Month) 27 (Day) 18 (Year)

7. AGE: 28 Yrs. 5 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: P. N. Kendall

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Jane Bills

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R M Kendall

(Address) .....

15. Filed 7-31 1916 W. P. Hamer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Accidental Drowning

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jas T McCann M. D.

8-1 1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Cemetery — DATE OF BURIAL: 8/2 1916

20. UNDERTAKER: Wm McBurney — ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24854

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15037
Registered No. 898

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
(No. ....., ... St.)

Registration District No. 78
Primary Registration District No. 2133

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary R. Hoover

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 20 (Day) 1914 (Year)

7. AGE: 1 yrs. 10 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pasco. Wash.

10. NAME OF FATHER: Charles F. Hoover

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Edna Salisbury.

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Edna Hoover
(Address) Pasco. Wash

15.
Filed July 3 1916 W.M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1916, to ..... 191..
that I last saw her alive on July 2 — 1916
and that death occurred on the date stated above, at 2. a.M.

The CAUSE OF DEATH* was as follows:

Whooping cough

..... (Duration) ..... yrs. 1 mos. 0 ds.
Contributory (Secondary) Sever. Congestion of lungs. Spasm
..... (Duration) ..... yrs. — mos. 1 ds.

(Signed) W.T. Jacquam M. D.
July 3 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lockport. New York
DATE OF BURIAL: July 1916

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Clarkfork
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2135
(No. ____, Clarkfork St.)

File No. 15038
Registered No. 899
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur C. Mann

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov 14 (Month) (Day) 1879 (Year)

7. AGE: 36 yrs. 7 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: W. E. Mann

11. BIRTHPLACE OF FATHER (State or Country): Not obtainable

12. MAIDEN NAME OF MOTHER: Susie Gallion

13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Agnes Mann
(Address) Clarkfork, Ida

15.
Filed June 4 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ July 4 1916 to ____ 191__, that I last saw h__ alive on ____ 191__ and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. W. Kinnaird M. D.
19__ (Address) Hope Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State ....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane, Wash. DATE OF BURIAL: July 6 1916

20. UNDERTAKER: Smith & Co ADDRESS: Spokane, Wash

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2133
File No. 15039
Registered No. 1900

1. PLACE OF DEATH.
County of Bonner
City of Clarkfork (No. ..., Clarkfork St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Mann

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb 6 (Month) (Day) 1907 (Year)

7. AGE: 9 yrs. 4 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ark

10. NAME OF FATHER: Arthur C. Mann

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Agnes Jones

13. BIRTHPLACE OF MOTHER (State or Country): Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Agnes Mann
(Address) Clarkfork Idaho

15.
Filed July 4 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 4th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~June~~ 7/4 1916 to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Accidental Drowning
(Duration) — yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) W. McKinnon M.D.
19... (Address) Hope

*State the DISEASE CAUSING DEATH; or, if deaths [illegible] (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence Clarkfork Idaho

19. PLACE OF BURIAL OR REMOVAL: Spokane, Wash. DATE OF BURIAL: July 6 1916

20. UNDERTAKER: [illegible] ADDRESS: Spokane

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Clagstone
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2155
(No. ....., ... St.)

File No. 15040
Registered No. 201
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Herman Becker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	White	Married

6. DATE OF BIRTH
..... (Month) ..... (Day) 1864 (Year)

7. AGE
52 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Farmer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Herman Becker
(Address) Clagstone Ida

15.
Filed July 8 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidentally Killed by falling of Bucket loaded with timber, a distance of 175' into bottom of well
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Knapp, Coroner M. D.
..... 19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spirit Lake	9th 1916
20. UNDERTAKER	ADDRESS
.....	Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15041

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 91

County of Clearwater Primary Registration District No. 2168

City of Elk River (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry E. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Feb (Month) 28 (Day) 1897 (Year)

7. AGE: 19 Yrs. 5 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Frank Smith

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Lyda Clive Summers

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Smith

(Address) Elk River

15.

Filed July 29 1916 Mrs. J. Dimon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 28th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1916, to July 28 1916, that I last saw h alive on July 28 1916, and that death occured on the date stated above, at 1735 M.

The CAUSE OF DEATH* was as follows:

Meningitis and peritonitis following a septic afflictions

(Duration) Yrs. mos. 28 ds.

Contributory (Secondary) .....

(Duration ... yrs. ... mos. ... ds.

(Signed) John Dimon M. D.

19 (Address) Elk River Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elk River, Idaho. DATE OF BURIAL: July 29 1916

20. UNDERTAKER: C. G. Morris ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. Mc

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78 Mc
Primary Registration District No. 2155
File No. 15042
Registered No. 963

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John E. De Huguet.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH.
Aug (Month) 1 (Day) 1840 (Year)

7. AGE
75 Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Bridge Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Retired.

9. BIRTHPLACE (State or Country): Quebec Canada

10. NAME OF FATHER: Francis Edward De Huguet

11. BIRTHPLACE OF FATHER (State or Country): Jersey Island.

12. MAIDEN NAME OF MOTHER: Gallaslan.

13. BIRTHPLACE OF MOTHER (State or Country): Jersey Islands

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. A. De Huguet
(Address) .....

15.
Filed July 12 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11 1916, to July 11 1916, that I last saw h[illegible] alive on July 11 1916, and that death occured on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrage

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.
July 11 1916 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lakeview Cemetery — DATE OF BURIAL: 7/13 1916

20. UNDERTAKER: [illegible] — ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78 Jackson

Primary Registration District No. 2155

File No. 15043

Registered No. 905

County of Bonner

City of Sandpoint (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jack Fletcher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 5 (Day) 1873 (Year)

7. AGE: 43 Yrs. 3 Mos. 19 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Deputy Sheriff
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ~~Ill~~ Mich

10. NAME OF FATHER: Jackson Fletcher

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Catherine Bell

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edith M. Fletcher
(Address) 424 Popular - City

15.
Filed July 24 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1914, to July 23 1916, that I last saw him alive on July 23 1916, and that death occured on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Basilar Meningeal Sclerosis. Apoplexy & Pneumonia Neuritis. Vomiting for 4 years (Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Used to be a hard drinker (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R H Jackson M. D.

19..... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: July 26 1916

20. UNDERTAKER: E M Brown — ADDRESS: S.P.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

2 P.M.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78 Jackson
Primary Registration District No. 215-5
File No. 15044
Registered No. 905

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gladys Lillian Askley.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 11 (Month) (Day) 1889 (Year)

7. AGE: 27 Yrs. 3 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stenographer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Spokane Wash.

10. NAME OF FATHER: J. H. Askley.

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Lillian Hodder

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alfred Askley
(Address) .....

15. Filed July 26 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1916, to July 25 1916, that I last saw her alive on July 25th 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Double Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R W Jackson M. D.
19..... (Address) Hagemann

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho | DATE OF BURIAL: July 27 1916

20. UNDERTAKER: E M Brower | ADDRESS: SP.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15045

Registered No. 19

1. PLACE OF DEATH.

Registration District No. 19

Primary Registration District No. 2005

County of Minidoka

City of Rupert Ida (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Williamson Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 25 (Day) 1841 (Year)

7. AGE: 75 Yrs. ..... Mos. — ds. 11

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: John Nelson

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Catharine Williamson

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Thomas

(Address) Burley Ida

15. Filed 7 - 9 1916

E H Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1916, to July 7, 1916, that I last saw h... alive on July 6, 1916, and that death occured on the date stated above, at 12:15 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of stomach

..... (Duration) ..... Yrs. 6? mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J B Scaggs M. D.

7/7 1916 (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Logan Utah — DATE OF BURIAL: July 10 1916

20. UNDERTAKER: H Holloday — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 58
County of Blaine Primary Registration District No. 2138 File No. 15047
City of Fairfield (No. ....., ... St.) Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Chas M Smith
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 26 (Day) 1861 (Year)

7. AGE: 55 yrs. ..... mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ore.

10. NAME OF FATHER: Cy Smith

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Sarah M Shaw

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph Smith
(Address) Blaine Idaho

15.
Filed 7-27 1916 D O Hagg Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 1916, to 1916
that I last saw him alive on July 27 1916,
and that death occurred on the date stated above, at 8:30 A. M.

The CAUSE OF DEATH* was as follows:
Gun shot wound in mouth
Self inflicted

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C A Stigg M. D.
7-27 1916 (Address) Fairfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairfield Idy — DATE OF BURIAL: 7-28 1916

20. UNDERTAKER: Sig Mansell — ADDRESS: Fairfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Carrel
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 57
Primary Registration District No. 2138
(No. ....., ... St.)

File No. 15048
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Jas C Bauerman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 4th (Day) 1842 (Year)

7. AGE: 73 yrs. 8 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Levy Bauerman

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Rebecca Hadman

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Mayfield
(Address) Carrel

15.
Filed 8-1 1916 DO Higgs Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1916, to July 31 1916, that I last saw h.... alive on July 29 1916, and that death occurred on the date stated above, at 2 a. M.

The CAUSE OF DEATH* was as follows:
Rocky Mountain Spotted Fever

(Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) DO Higgs M. D.
7-31-1916 (Address) Fairfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Carrel Idaho — DATE OF BURIAL: Aug 2 1916

20. UNDERTAKER: Sig Morrell — ADDRESS: Fairfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15050

Registered No. 15

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. Black Cloud Mill St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Antonietta Caron

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 22 (Day) 1 (Year)

7. AGE: 0 Yrs. 0 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Black Cloud.

10. NAME OF FATHER: Umberto Coiron

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Matilda Cian

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Matilda Caron

(Address)

15. Filed Jul 16 1916 W. C. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1916, to July 14, 1916, that I last saw h[illegible] alive on July 14, 1916, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) D. W. Mowry M. D.

July 17 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Id — DATE OF BURIAL: July 15 1916

20. UNDERTAKER: B. G. Norvell — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 22

Primary Registration District No. 2208

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1551

Registered No. 19

1. PLACE OF DEATH.

County of Shoshone

City of Wallace (No. Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Beatrice Hallie Benson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct (Month) 24 (Day) 1903 (Year)

7. AGE: 12 Yrs. 9 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Student

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Salmo B. C.

10. NAME OF FATHER Bert Benson.

11. BIRTHPLACE OF FATHER (State or Country) Ava. Illinois

12. MAIDEN NAME OF MOTHER Dora Hiser.

13. BIRTHPLACE OF MOTHER (State or Country) Ava. Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora Masson.

(Address) Wallace Ida.

15. Filed 7/28 1916 H. L. Mowry Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 25th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gunshot Wound
Thro the head Suicide

(Duration) ..... Yrs. ..... mos. 1/2 ds.

Contributory (Secondary) Poverty

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) H. L. Mowry Coroner.

7/28 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: July 27 1916

20. UNDERTAKER: Ward Mud Co — ADDRESS: Wallace Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1256
Primary Registration District No. 2505
(No. ..... St.)

File No. 15052
Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Avery

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucia Laura Olson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. (Month) 28 (Day) 1906 (Year)

7. AGE: 9 Yrs. 8 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Lewis Olson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Maud Tibbitts

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Lewis Olson
(Address) St Maries

15. Filed July 24 1916. H. I. Mowry Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Drowned body found Jul 22nd

(Duration) ..... Yrs. Instant ds.
Contributory (Secondary) None
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas R. Mowry Coroner
June 19 16 (Address) Wallace, Ida.

*Give the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene — DATE OF BURIAL ....191...

20. UNDERTAKER: A B Smith — ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17

Primary Registration District No. 2200

File No. 15053

Registered No. 17

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. Cameron Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Esther Parr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 72 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nova Scotia

10. NAME OF FATHER: H. Hewitt

11. BIRTHPLACE OF FATHER (State or Country): Nova Scotia

12. MAIDEN NAME OF MOTHER: Jane Lee

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Stevens

(Address)

15. Filed 7/20 1916 W. D. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1916 to July 18 1916, that I last saw h[illegible] alive on July 18 1916, and that death occured on the date stated above, at 10P M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 10 Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) D. M. Mowry M. D.

(Address) Wallace Ida

July 21 19

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence: Missoula Mont.

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL ... 191...

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & BOOK. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 122
Primary Registration District No. 2280

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1554
Registered No. 16

1. PLACE OF DEATH.
County of Shoshone
City of Richmond mine (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hans E. Linn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Meh (Month) 4 (Day) 1880 (Year)

7. AGE: 36 Yrs. 4 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: E Linn

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Anna Olson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ole Linn
(Address) Wallace Ida

15. Filed 7/20 1916 H C Moore Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jul (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on Jul 17 1916,
and that death occured on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:
Acute alcoholism
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Exposure
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H C Moore M. D.
7/7 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: July 19 1916

20. UNDERTAKER: B G Worstell
ADDRESS: Wallace

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31
File No. 15[illegible]55

1. PLACE OF DEATH.
County of Benewah,
City of Desmet.
(No. ....., ... St.)
Primary Registration District No. .....
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Prosper.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 15th, 1915
(Month) (Day) (Year)

7. AGE ——Yrs. 4 Mos. ——ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Coeur D'Alene Reservation

10. NAME OF FATHER: Thomas Prosper

11. BIRTHPLACE OF FATHER (State or Country): Coeur D Aleme Reservation

12. MAIDEN NAME OF MOTHER: Mary Basille

13. BIRTHPLACE OF MOTHER (State or Country): Coeur D,Alene Reserv

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas Prosper,
(Address) Coeur D,Alene Reservation
Desmet Idaho

15.
Filed July 27 1916
John Post Asst.
Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July, 24th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17th 1916 to July24th 1916, that I last saw him alive on July 24th 1916, and that death occured on the date stated above, at 9. P M.

The CAUSE OF DEATH* was as follows:
Broneho Pneamonia.

.....(Duration) — Yrs. — mos. 7 ds.

Contributory (Secondary) .....(Duration — yrs. 4 mos. — ds.

(Signed) Eugene M. Kane U.S.I.M.S.D.
19.... (Address) Desmet Idaho,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Desmet Idaho,
DATE OF BURIAL: July27 1916

20. UNDERTAKER: John Post
ADDRESS: Desmet

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15056

Registered No. .....

1. PLACE OF DEATH.

Registration District No .....

Primary Registration District No .....

County of Benewah

City of Desmet Ida.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME ~~Andrew Yumas~~ Adrian Yumas ~~ANDREW YUMAS~~

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Indian	~~Married~~

6. DATE OF BIRTH.

July (Month) 1st (Day) 1831 (Year)

7. AGE

85 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Coeur D,Alene Reserv.

10. NAME OF FATHER Sulemt Kane

11. BIRTHPLACE OF FATHER

(State or Country) Coeur D,Alene Reserv

12. MAIDEN NAME OF MOTHER Victoria Paul ~~Pitcher Paul~~

13. BIRTHPLACE OF MOTHER

(State or Country) Coeur D,Alene Reserv.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Moctelme

(Address) Coeur D.Alene Reserv. DeSmet, Idaho

15.

Filed July 2 1916 John Post Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26th 1916, to July 1st 1916, that I last saw him alive on July 1st 1916 and that death occured on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumenia.
and Inamition.

5 (Duration) — Yrs. 1 mos. 4 ds.

Contributory (Secondary) Senility.

---- (Duration 2 yrs. — mos. — ds.

(Signed) Eugene N. Hill M. D.

19.... (Address) Desmet Idaho U.S.I.S.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL OR REMOVAL~~ Burial: Desmet Cemetery — DATE OF BURIAL July 5 1916

20. UNDERTAKER ~~Felix~~ John Post — ADDRESS DeSmet, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31
Primary Registration District No.
(No. , St.)

File No. 15057
Registered No.

1. PLACE OF DEATH.
County of Benewah
City of Desmet

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Angelique, Moses

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH. Jan'y (Month) 19 (Day) 1901 (Year)

7. AGE: 15 Yrs. 5 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Coeur D Alene Reservation

10. NAME OF FATHER: Moses Big Frank's Bro.

11. BIRTHPLACE OF FATHER
(State or Country) Coeur D Alene Reservation

12. MAIDEN NAME OF MOTHER: Marie Agnes Leo

13. BIRTHPLACE OF MOTHER
(State or Country) Coeur D Alene Reservation

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Agnes Leo
(Address) Desmet, Ida.

15.
Filed July 12 1916 John Post Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 11th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1916, to July 11th 1916, that I last saw her alive on July 11th 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary) Inanition and anaemia

(Duration 1 yrs. — mos. — ds.

(Signed) Eugene M. Neal M. D.

19 (Address) Desmet Idaho U.S.I.S.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Desmet Idaho,
DATE OF BURIAL: 12 July 1916

20. UNDERTAKER: John Post
ADDRESS: Desmet Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonneville — Registration District No. 21

City of DeSmet, Ida — Primary Registration District No. ____

(No. ____, ____ St.)

File No. 15058

Registered No. ____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Moses Peone.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 6 (Day) 1908 (Year)

7. AGE: 8 Yrs. 1 Mos. 27 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School Boy,

(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Coeur D Alene Reserv.

10. NAME OF FATHER: Louis Peone,

11. BIRTHPLACE OF FATHER (State or Country): Coeur D Alene Reserv.

12. MAIDEN NAME OF MOTHER: Philomena Vallee

13. BIRTHPLACE OF MOTHER (State or Country): ~~XXXXXX~~ Flathead Reserv

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Peone.

(Address) Desmet Idaho.

15. Filed July 24 1916 — John Peat Asst. — Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1916, to July 3 1916, that I last saw him alive on July 2nd, 1916, and that death occured on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary): Inanition & Sepsis,

(Duration — yrs. — mos. — ds.

(Signed) Eugene M. Hill M. D.

19 (Address) Desmet Ida U.S.A.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Sorrento, Ida (Reservation) — DATE OF BURIAL: July 5 1916

20. UNDERTAKER: Louis Peone — ADDRESS: DeSmet, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Medimont
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 126
Primary Registration District No. 2204
(No. ..... St.)

File No. 15059
Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lizzie W. C. Horton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Sept. (Month) 26 (Day) 1890 (Year)
7. AGE: 25 Yrs. 9 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Mo.
10. NAME OF FATHER: D. Horton
11. BIRTHPLACE OF FATHER (State or Country): Mo.
12. MAIDEN NAME OF MOTHER: L. Glover
13. BIRTHPLACE OF MOTHER (State or Country): Mo.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Lottie Horton
(Address) Carterville Mo.
15.
Filed Aug 7 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 21 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 20 1916, to July 21 1916,
that I last saw h. alive on July 20 1916,
and that death occured on the date stated above, at 12 25 M.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
of both lungs Left lung
involved.
(Duration) about 1 Yrs. 6 mos. ds.
Contributory (Secondary) Pulmonary hemorrhage
(Duration ..... yrs. mos. 14 ds.
(Signed) J. R. Gates M. D.
7/21 1916 (Address) Rathdrum, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. 1 days
Where was disease contracted if not at place of death? Probably in Kansas City Mo.
Former or usual residence Kansas City, Mo.

19. PLACE OF BURIAL OR REMOVAL: Webb City Mo — DATE OF BURIAL 191...
20. UNDERTAKER per Gus Nelson — ADDRESS Carterville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRD - VOSS CO., PTRS. & BDRS. 94658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15061
Registered No. 18

1. PLACE OF DEATH.
County of Kootenai
City of Harrison
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Genatemi DeLucca

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	married

6. DATE OF BIRTH June 18 1866
~~July 22~~ ~~1870~~
(Month) (Day) (Year)

7. AGE
50 yrs. 1 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER Jno Varettoni

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER .

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mat Lalu
(Address) Harrison

15.
Filed Aug 7 1916 B L Jensen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July 29 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1916, to July 29 1916, that I last saw her alive on July 28 1916, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

uremia

(Duration) ..... yrs. ..... mos. one ds.

Contributory (Secondary) Paralysis + nephritis

(Duration) 2 yrs. — mos. — ds.

(Signed) J. W. Didier M. D.

July 29 1916 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Harrison Cem	Aug 1 1916

20. UNDERTAKER	ADDRESS
Egan Bros	Harrison

24

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2153
File No. 15263
Registered No. .....

1. PLACE OF DEATH.
County of Custer
City of Mackay
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pete Aldabalbal

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mackay, Idaho

10. NAME OF FATHER: Joe Aldabalbal

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Florentina Billoa

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joe aldabalbal
(Address) Mackay Ida.

15. Filed Aug 9 1916 R. Marin Deputy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to May 20 1916, that I last saw him alive on May 19 1916, and that death occured on the date stated above, at 7a. M.

The CAUSE OF DEATH* was as follows:

Pertusis

..... (Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) Pneumonia Bronchial

..... (Duration) ..... Yrs. ..... mos. 3 ds.

(Signed) W. H. Farrell M. D.

3/20 1916 (Address) Mackay Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mackay Ida — DATE OF BURIAL: 5/21 1916

20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2153
File No. 15064
Registered No. .....

1. PLACE OF DEATH.
County of Custer.
City of Mackay.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benkat Magdaw

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Spanish White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Unknown. (Month) (Day) 1891 (Year)
7. AGE: 25 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Spain.
10. NAME OF FATHER: Unknown.
11. BIRTHPLACE OF FATHER (State or Country): Spain.
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Spain.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....
15. Filed July 29th 1916 R. Marie Sieg Local Registrar

SYMS - YORK CO., PTRS. & RORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Found dead at bottom of mine shaft with broken neck
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) W. H. Farrell M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mackay, Ida. DATE OF BURIAL: July 29 1916
20. UNDERTAKER: J. H. Baxter ADDRESS: Mackay Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. D 15065

Registered No.

1. PLACE OF DEATH.
County of Cassia
City of Oakley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 120
Primary Registration District No. 2199
(No. , St.)

2. FULL NAME Read Worthington

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: June (Month) 13 (Day) 1888 (Year)
7. AGE: 28 yrs. 1 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Oakley Idaho
10. NAME OF FATHER: Joseph McMurray
11. BIRTHPLACE OF FATHER (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Antoinette Curtis
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. H. Worthington
(Address) Oakley Idaho
15.
Filed 8/10 1916 E. P. Oldham Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 25 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 10 1916, to July 25 1916, that I last saw h er alive on July 25 1916, and that death occurred on the date stated above, at 9 M.
The CAUSE OF DEATH* was as follows:
Tuberculosis
(Duration) 5 yrs. — mos. — ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) T. F. Nelson M. D.
1/26 1916 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho
DATE OF BURIAL: 7-27 1916
20. UNDERTAKER: J. F. Adams
ADDRESS: Oakley Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 120
Primary Registration District No. 2199
File No. D 15066
Registered No. 17

1. PLACE OF DEATH.
County of Cassia
City of Oakley (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Critchfield
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH July 25 1916
(Month) (Day) (Year)

7. AGE ..... yrs. ..... mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER A.W. Critchfield

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Maud McIntosh

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A.W. Critchfield
(Address) Oakley Idaho

15. Filed 8/10 1916 E.P. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug. 5 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:

Unknown
no Doctor attending
.....(Duration).....yrs.....mos.....ds.

Contributory (Secondary) .....
.....(Duration).....yrs.....mos.....ds.

(Signed) E.P. Johnson M. D.
8/6 1916 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho — DATE OF BURIAL: 8/6 1916

20. UNDERTAKER: Jacks & Critchfield — ADDRESS: Oakley Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Custer
City of Custer
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 7
Primary Registration District No. 2006.
(No. ....., ... St.)

File No. 15067
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel Burgess

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	White	widower.

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1 (Year)

7. AGE
nearly 60 yrs.
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Sheepherder

9. BIRTHPLACE (State or Country) Dont Know

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S B Shellaberger
(Address) Kamiah Idaho

15.
Filed July 8 1916 Dr. Dalonge
Local Registrar
Deputy S B Shellaberger

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 1916, to July 6 1916, that I last saw him alive on July 5 1916, and that death occured on the date stated above, at 7 a. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia, with subsequent pulmonary hemorrhage.
..... (Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) ←
..... (Duration ← yrs. ← mos. ← ds.
(Signed) J. B. Smith M. D.
7/10-1916 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Kohlerfarm — DATE OF BURIAL July 8 1916

20. UNDERTAKER S B Shellaberger — ADDRESS Kamiah Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & PUBS. 24054

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9C
Primary Registration District No. 1009
File No. 15068
Registered No. 1

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 818 Main St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank H Eichler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June 7 (Month) (Day) 1864 (Year)

7. AGE: 52 Yrs. 1 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Summer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Prussia

10. NAME OF FATHER: Chas. Eichler

11. BIRTHPLACE OF FATHER (State or Country): Berlin Ger.

12. MAIDEN NAME OF MOTHER: F Fredericken

13. BIRTHPLACE OF MOTHER (State or Country): Berlin Ger.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Mary A Eichler
(Address) Portland Ore.

15. Filed 8-10- 1916 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1916, to July 8 1916, that I last saw h-- alive on July 8 1916, and that death occured on the date stated above, at 9 a M.

The CAUSE OF DEATH* was as follows:

Acute alcoholism

(Duration) — Yrs. — mos. 2 ds.

Contributory (Secondary): Prohibition

(Duration ..... yrs ..... mos. ..... ds.

(Signed) L J Perkins M. D.

8/8 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 1916

20. UNDERTAKER: Lasson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 15070
Registered No. 3

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 324 2nd Ave E St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary E Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. July 14 1837 (Month) (Day) (Year)
7. AGE: 79 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): NY
10. NAME OF FATHER: Chas L Kelley
11. BIRTHPLACE OF FATHER (State or Country): NY
12. MAIDEN NAME OF MOTHER: Susan Mack
13. BIRTHPLACE OF MOTHER (State or Country): NY
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs J J Jennings
(Address) Lewiston Idaho
15. Filed 8-10 191C L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 20 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 1 1916, to July 20 1916, that I last saw h[illegible] alive on July 20 1916 and that death occured on the date stated above, at [illegible] M.
The CAUSE OF DEATH* was as follows:
Cancer of the Kidney.
..... (Duration) 6 Yrs. ..... mos. ..... ds.
Contributory (Secondary): Ind. Known
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) John C. Alley M. D.
7-20 1916 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: July [illegible] 1916
20. UNDERTAKER: C Watson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNG - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9C
Primary Registration District No. 5039
File No. 15071
Registered No. 44

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. St. Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ira Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 6 (Day) 1905 (Year)

7. AGE: 10 Yrs. 4 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Scholar
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: H. J. Thomas

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Hattie Dodson.

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry J. Thomas
(Address) Reubens

15. Filed 8-10-1916 L. J. Perkins Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1916, to July 24 1916, that I last saw h[illegible] alive on July 24 1916, and that death occured on the date stated above, at 8 55 P. M.

The CAUSE OF DEATH* was as follows:
Intestinal Hemorrhage
(Duration) Yrs. 3 mos. ds.
Contributory (Secondary): Inflammation, Bld
(Duration) yrs. 7 mos. ds.
(Signed) John R. Allen M. D.
7-25 1916 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos. 21 days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? Reubens
Former or usual residence Reubens Idaho

19. PLACE OF BURIAL OR REMOVAL: Reubens
DATE OF BURIAL ..... 191..

20. UNDERTAKER: [illegible] Wasson
ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9c
Primary Registration District No. 1009
File No. 15072
Registered No. 5

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. White Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W P Bounds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Feb (Month) 26 (Day) 1854 (Year)

7. AGE: 62 Yrs. 4 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon.

10. NAME OF FATHER: W P Bounds.

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: P. Linnell

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W Wade Bounds
(Address) Lewiston Ida. Box 56

15. Filed 8-10- 191 1 — J. G. Perkins, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1916, to July 24 1916, that I last saw h alive on July 24 1916, and that death occured on the date stated above, at 1-0 M.

The CAUSE OF DEATH* was as follows:
Unsterlcal Nephritis

(Duration) 10 Yrs. mos. ds.
Contributory (Secondary): Not known
(Duration yrs. mos. ds.

(Signed) John H Alley M. D.
7-25 1916 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos. 7 days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: July 27 1916

20. UNDERTAKER: C J Vassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 15873
Registered No. 146

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. Whites Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Nelson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Sept (Month) 1 (Day) [illegible] (Year)

7. AGE: 79 Yrs. 10 Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont Ill

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fred E. Grosse
(Address) Lewiston Ida.

15. Filed 8-10- 1916 L Watkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20th 1916, to July 31 1916, that I last saw him alive on July 31 1916, and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(Duration) 2 Yrs. mos. ds.
Contributory (Secondary): General Carcinoma
(Duration) 2 yrs. mos. ds.

(Signed) Edgar L. White M. D.
Aug 1 19 16 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston, Idaho
DATE OF BURIAL: 191

20. UNDERTAKER: C. J. Vassar
ADDRESS: Lewiston

SYMS - YORK CO., PTRS. & BDRS. 24659

FORM V. S. No. 5-25 M. 1-16-13

15074

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 14
Registered No. 13

1. PLACE OF DEATH.

County of Boise
City of Horseshoe Bend

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles E. Mitchell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.

7 (Month) 14 (Day) 1889 (Year)

7. AGE

17 Yrs. 7 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Pennsylvania

10. NAME OF FATHER
Andrew Mitchell

11. BIRTHPLACE OF FATHER
(State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER
Lee Mort

13. BIRTHPLACE OF MOTHER
(State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andy Mitchell
(Address) Horseshoe Bend

15.

Filed July 7 1916

E Vadney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1916, to July 6 1916, that I last saw h.im alive on July 2 1916, and that death occured on the date stated above, at 3- P.M.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

(Duration) Yrs. 7 mos. ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E Vadney M. D.

7-7 1916 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? Idaho

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Horseshoe Bend — DATE OF BURIAL: July 9 1916

20. UNDERTAKER: Andy Mitchell — ADDRESS: Horseshoe Bend

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

15075

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16

Registered No. 13

1. PLACE OF DEATH.

County of Boise

City of Lucas

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John W Handlers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. July (Month) 18 (Day) 1860 (Year)

7. AGE: 66 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mar

10. NAME OF FATHER: da nat Knave

11. BIRTHPLACE OF FATHER (State or Country): Mar

12. MAIDEN NAME OF MOTHER: Handaugh

13. BIRTHPLACE OF MOTHER (State or Country): Mar

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H A Vahlberg
(Address) Lucas Idaho

15.
Filed 7-19 1916
E Vadney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
7 (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 , to 191 ,
that I last saw h alive on 191 ,
and that death occured on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Accident
Killed by a Falling Building
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) E Vadney M. D.
19 (Address) Lucas

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Braundee Idaho
DATE OF BURIAL: 7-21 1916

20. UNDERTAKER: H A Vahlberg
ADDRESS: Lucas

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & ENGR. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3 15076
Registered No. 8

1. PLACE OF DEATH.
County of Canyon
City of Fruitland
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 2130
(No. ——, ——St.)

2. FULL NAME Dallas Lyle Schubert

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Aug (Month) 18 (Day) 1914 (Year)

7. AGE: 1 yrs. 11 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: L. Z. Schubert

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Effie Smith

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. Z. Schubert
(Address) Fruitland Ida

15.
Filed Aug. 10 1916 Crispin Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1916, to July 20 1916
that I last saw h— alive on July 20 1916
and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Septicemia (Streptococcic)

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William J Weese M. D.
7/20 1916 (Address) Ontario, Ore.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Cem Payette | DATE OF BURIAL: July 21 1916

20. UNDERTAKER: D. N. McClain | ADDRESS: Fruitland Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15077

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Elmore

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 2177

(No. ....., ... St.)

2. FULL NAME Ethel Welch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct (Month) 24 (Day) 1914 (Year)

7. AGE: 1 Yrs. 8 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER John W Welch

11. BIRTHPLACE OF FATHER (State or Country) Bennington Idaho

12. MAIDEN NAME OF MOTHER Louie Howells

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Welch

(Address) .....

15. Filed July 16 1916 Walter Local Registrar

SYMS-YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1916, to July 14 1916, that I last saw h.. alive on July 14 1916, and that death occured on the date stated above, at 4 50 P. M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

six weeks

(Duration) ..... Yrs. 21 mos. 5 ds.

Contributory (Secondary) .....

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Glenns Ferry — DATE OF BURIAL: July 17 1916

20. UNDERTAKER: None — ADDRESS: —

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 41

Primary Registration District No. 2116

File No. 15078

Registered No. 134

County of Lemhi

City of Salmon Idaho (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robt Martin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Do not know (Month) (Day) (Year)

7. AGE: 77 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Died at County Farm

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Do not know

10. NAME OF FATHER: Do " "

11. BIRTHPLACE OF FATHER (State or Country): " " "

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W C Hoeble

(Address) Salmon Idaho

15. Filed July 15 1916 E D Herndon Local Registrar

SYMS - YORK CO., PTRS. & BKBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 15th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1915, to July 1916, that I last saw him alive on July 14th 1916 and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration 1 yrs. 1 mos. ..... ds.

(Signed) F. S. Wright M. D.

7/15 1916 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 7-16" 1916

20. UNDERTAKER: W C Hoeble — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERM... MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
(No. ..... St.)

File No. 15079
Registered No. 735

1. PLACE OF DEATH.
County of Lemhi
City of Salmon

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Crawford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH. October 22nd 1828
(Month) (Day) (Year)

7. AGE: 87 Yrs. 10 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Quartz Miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Scotland

10. NAME OF FATHER Dont know

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Dont know

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mr C Bates
(Address) Salmon Idaho.

15. Filed July 27 1916 Edith O'Hendren Local Registrar

SYMS - YORK CO., PTRS. & RULR. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 27th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1912, to July 27" 1916, that I last saw h alive on July 27" 1916, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows: Paralysis

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Whitsett M. D.
July 27" 1916 (Address) Salmon Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: July 28" 1916

20. UNDERTAKER: W. C. Hoobler — ADDRESS: Salmon Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 1017-2017
File No. 15080
Registered No. .....

1. PLACE OF DEATH.
County of Lincoln
City of Jerome
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ada D. Cunningham

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 17 (Day) 1875 (Year)

7. AGE: 41 Yrs. 11 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Samuel Smail

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. M. Cunningham
(Address) Jerome, Ida.

15. Filed July 17 1916 — E. D. Pike, Local Registrar

SVMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:

Stroke of Lightening

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) E. D. Pike M. D.
7/17 1916 (Address) Jerome

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jeanette Pa — DATE OF BURIAL ..... 191...

20. UNDERTAKER: D. A. Peterson — ADDRESS: Jerome Ida

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15081

Registered No.

1. PLACE OF DEATH
County of Lincoln
City of Jerome (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 1017-2017

2. FULL NAME John S Hedricks

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH: June (Month) 11 (Day) 1868 (Year)

7. AGE: 48 yrs. 1 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Chas Hedricks

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Ruth McGraeen

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Hedricks
(Address) Jerome Ida

15.
Filed Aug 3 1916 E. D. Piper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1916, to Aug 1st 1916, that I last saw him alive on Aug 1st 1916, and that death occurred on the date stated above, at 12 a. M.

The CAUSE OF DEATH* was as follows:

Acute Gastritis with severe vomiting 2 hours.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Heart failure - Chronic Rheumatic Heart

(Duration) several yrs. ..... mos. ..... ds.

(Signed) E. D. Piper M. D.

6/3/1916 (Address) Jerome, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was Disease contracted, if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Memorial Cemetery — DATE OF BURIAL: Aug 3 1916

20. UNDERTAKER: L. A. Sheridan Jerome — ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

BYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 87
Primary Registration District No. 2154
(No. ....., ... St.)

File No. 15083
Registered No. .....

1. PLACE OF DEATH.
County of Washington
City of .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Little

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. June (Month) 10 (Day) 1902 (Year)

7. AGE: 14 Yrs. ..... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER George Little

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Alice Jones

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Georg Little
(Address) .....

15. Filed June 14 1916 W. O. Marshall Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1916, to June 12 1916, that I last saw her alive on June 10 1916, and that death occured on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Cirrhosis of Pancreas
.....
.....
(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. E. Schmuck M. D.
6-14 1916 (Address) Midvale Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Midvale
DATE OF BURIAL: June 14 1916

20. UNDERTAKER: A. W. Williams
ADDRESS: Midvale

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 87
Primary Registration District No. 2154
File No. 15084
Registered No. .....

1. PLACE OF DEATH.
County of Washington
City of Midvale (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Austin Stewart
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: [illegible]

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. March 12 1844 (Month) (Day) (Year)

7. AGE: 72 Yrs. 1 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or 4.2 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri - Wash. Co.

10. NAME OF FATHER: Riley Stewart

11. BIRTHPLACE OF FATHER (State or Country): United States

12. MAIDEN NAME OF MOTHER: Sarah Vanderpool

13. BIRTHPLACE OF MOTHER (State or Country): United States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. F. Stewart & F. J. Stewart
(Address) Midvale, Idaho.

15. Filed Aug. 14 1916 — W. A. Marshall, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1916, to Apr. 16 1916, that I last saw h[illegible] alive on Apr. 16 1916, and that death occured on the date stated above, at 7.0 M.

The CAUSE OF DEATH* was as follows:

Cancer of Throat

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Marshall M. D.
Apr. 17 1916 (Address) Midvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Midvale — DATE OF BURIAL: Apr. 17 1916

20. UNDERTAKER: A. Williams — ADDRESS: Midvale

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15085

Registered No. .....

1. PLACE OF DEATH.

County of Washington

City of Midvale

(No. ....., ... St.)

Registration District No 87

Primary Registration District No 3184

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nichols

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. (Month) 1 (Day) 1916 (Year)

7. AGE: .....Yrs. 6 Mos. 9 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ida.

10. NAME OF FATHER L. E. Nichols

11. BIRTHPLACE OF FATHER (State or Country) Tex.

12. MAIDEN NAME OF MOTHER Ora Ford

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ora Nichols

(Address) Midvale Ida.

15.

Filed Aug. 9 1916

W. D. Marshall
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August. (Month) 8 (Day) 191. (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 6 191., to August 8 191., that I last saw him alive on August 7 1916, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Dysentery

[also nephritis Inanition

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Malnutrition food

(Duration ..... yrs. 6 mos. 1 ds.

(Signed) C. E. Schmutz M. D.

8-9-1916 (Address) Midvale Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: .....

DATE OF BURIAL: Aug 11 1916

20. UNDERTAKER: A. Williams

ADDRESS: Midvale

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6 15086

Registered No. 44

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No. 29

Primary Registration District No. 1050

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) ..... 1 (Year)

7. AGE: About 45 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed 8-4 1916 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Don't Know ..... 191 ..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——, 191, to —— 191, that I last saw h— alive on —— 191, and that death occured on the date stated above, at —— M.

The CAUSE OF DEATH* was as follows:

Found dead in house at S. P. Ry. August 3rd at Hewitt Idaho.

—— (Duration) — Yrs. — mos. — ds.

Contributory (Secondary) .....

— (Duration — yrs. — mos. — ds.

(Signed) J. Barnes Coroner. M. D.

8-4-1916 (Address) 611 Garden Ave Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	Aug. 4 1916
20. UNDERTAKER	ADDRESS
E. C. Hedlund	C D A.

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai — Registration District No. 29

City of Coeur D'Alene — Primary Registration District No. 1056

(No. .... St.)

File No. 6 15087 45

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franz Gustaf Swanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Apr (Month) 19 (Day) 1894 (Year)

7. AGE 22 Yrs. 3 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Minn

10. NAME OF FATHER John A. Swanson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Carrie Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Carl Swanson.
(Address) Coeur D'Alene

15. Filed 8-6 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1916, to Aug 6 1916, that I last saw h.. alive on Aug 6 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary hemorrhage
from tubercle erosion of
pulmonary artery
(Duration) 6 Yrs. 6 mos. 6 ds.

Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Hoeden M. D.
8/6 1916 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetary	Aug. 9 1916
20. UNDERTAKER	ADDRESS
Cassedy & Nelson	Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6 15088

Registered No. 46

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D'Alene

Registration District No. 29

Primary Registration District No. 1050

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Sutherland Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 23 (Day) 1900 (Year)

7. AGE: 15 Yrs. 11 Mos. 8 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Student

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER George Sutherland

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Mary V. Bangs

13. BIRTHPLACE OF MOTHER (State or Country) Connecticut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Sutherland

(Address) .....

15. Filed 8-1 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1916, to Aug 1 1916, that I last saw h. alive on Aug 1 1916, and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:

Surgical Shock following operation for appendicial abscess

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Appendicitis

(Duration ..... Yrs. ..... mos. 10 ds.

(Signed) J. C. Burgess M. D.

8/1 1916 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Aug 2 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 615089

Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D' Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29

Primary Registration District No. 1050

2. FULL NAME Anna Virginia Bee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 19 (Day) 1857 (Year)

7. AGE: 65 Yrs. 3 Mos. 27 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Wm Oliver

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs H M Hansen
(Address) Coeur D'Alene, Idaho

15. Filed July 17 1916 — A. Hughes, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Mrs Haddad was not seen until after death occurred. Probable Cardiac Disease,
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J A Wayne M. D.
7/17 1916 (Address) Coeur d'Alene, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: 191...

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene
(No. ..... St.)

Registration District No. 29
Primary Registration District No. 1056

File No. 615090
Registered No. 78

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Casey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 6 (Day) 1825 (Year)

7. AGE: 91 Yrs. 1 Mos. 9 ds.
IF LESS than 1 day how many .....hrs. or .....min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: John Casey

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Margaret

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant):
(Address): James Casey

15. Filed July 17 1916
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 1916, to July 15 1916, that I last saw h[illegible] alive on July 15 1916, and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Brown M. D.
July 17 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Thomas Cemetery
DATE OF BURIAL: July 18 1916

20. UNDERTAKER: Cassell & Nelson
ADDRESS: Coeur d'Alene

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene (No. ....., ... St.)
Registration District No. 29
Primary Registration District No. 1050
File No. 7 15091
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm McMeekin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Nov. (Month) 29 (Day) 1830 (Year)

7. AGE: 85 Yrs. 8 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Mc Meekin

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Jane [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs G. I. Faulkner
(Address) .....

15. Filed 8-1 1916
D. Hughes
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
~~Aug.~~ July (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1916, to July 31 1916, that I last saw h in alive on July 1 1916 and that death occured on the date stated above, at 5P M.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Hayes M. D.
8/1 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Aug 2 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur d'Alene

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15092

Registered No. 2

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene (No. ....., ... St.)

Registration District No. 29

Primary Registration District No. 1050

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hiram Hollis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. July (Month) 30 (Day) 1829 (Year)

7. AGE: 87 Yrs. 10 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Filer in

(b) General nature of industry, business, or establishment in which employed (or employer): Sawmill

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: James Hollis

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Claud Hollis

(Address) Coeur D'Alene

15. Filed July 17 1916 O. Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1916, to July 16 1916, that I last saw him alive on July 16 1916, and that death occured on the date stated above, at 2.50 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) — Yrs. — mos. 10 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Alexander Gavin M. D.

7/17/1916 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: July 17 1916

20. UNDERTAKER: T. E. Reed — ADDRESS: C. d'A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOK. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of C d A

Registration District No. 29

Primary Registration District No. 29 1256

(No. ..... St.)

File No. 15093

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rachel Finley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Wid

6. DATE OF BIRTH. (Month) (Day) 1855 (Year)

7. AGE: 61 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... —

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country): Pa

10. NAME OF FATHER: Samuel Wright

11. BIRTHPLACE OF FATHER (State or Country): Maryland

12. MAIDEN NAME OF MOTHER: Elizabeth Counts

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emma Harris

(Address) Post Falls

15. Filed July 20 1916

D. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17 1916, to July 19 1916, that I last saw h[illegible] alive on July 18 1916, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) J. O'Neil M. D.

7/19 1916 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem

DATE OF BURIAL: July 21 1916

20. UNDERTAKER: S J Puncan

ADDRESS: C d A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15094
Registered No. 132

1. PLACE OF DEATH.
County of Lemhi
City of Tendoy (No. ....., ... St.)
Registration District No. 41
Primary Registration District No. 2116

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Shorey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 11 (Month) 11 (Day) 1881 (Year)

7. AGE: 34 yrs. 8 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Francis B. Shorey

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Rebecca Catey

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Shorey
(Address) Tendoy, Ida

15.
Filed July 16 1916 Ed Herndon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 7 (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10" 1916, to July 14 1916, that I last saw him alive on July 14 1916, and that death occurred on the date stated above, at 4:00 P. M.

The CAUSE OF DEATH* was as follows:
Hemmorrhage of brain
result of accident

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Watts M. D.
7/17 1916 (Address) Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dewey Cemetery Tendoy, Ida
DATE OF BURIAL: 7/17 1916

20. UNDERTAKER: W. C. Dorris
ADDRESS: Salmon Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 15095
Registered No. 133

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carrie Bell Finch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH. October (Month) ..... (Day) 1856 (Year)
7. AGE: 59 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): New York
10. NAME OF FATHER: Mr Pierson
11. BIRTHPLACE OF FATHER (State or Country): Do not know
12. MAIDEN NAME OF MOTHER: Miss May Farran
13. BIRTHPLACE OF MOTHER (State or Country): New York
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Prentice Finch
(Address) North Fork
15. Filed July 15 1916 Ed. Herndon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 15th (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 7 1916, to July 15 1916, that I last saw h[er] alive on July 15 1916, and that death occured on the date stated above, at 9 a.m.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach & Liver
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) F J Wright M. D.
7/15 1916 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 7-16-1916
20. UNDERTAKER: W. C. Doebler — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 20
Primary Registration District No. 2077
(No. .... St.)

File No. 15096
Registered No. .....

1. PLACE OF DEATH.
County of Power
City of Am Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Bethke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widower

6. DATE OF BIRTH.
Oct (Month) 30 (Day) 1866 (Year)

7. AGE
79 Yrs. 9 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Bethke

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert Bethke
(Address) Am Falls

15.
Filed July 3 1916
R. F. North
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 9a M.
The CAUSE OF DEATH* was as follows:

Apoplexy
not in attendance,
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Richard F North M. D.
7/11 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Am Falls
DATE OF BURIAL: 7/13 1916

20. UNDERTAKER: A P Hager
ADDRESS: Am Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2072
File No. 15097
Registered No. .....

1. PLACE OF DEATH.
County of Power
City of Am Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Claude Edward Albert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Single~~ Married

6. DATE OF BIRTH: Nov (Month) 17 (Day) 1889 (Year)

7. AGE: 26 Yrs. 7 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Edward H. Albert

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Florence Ray

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert A. Albert
(Address) America Falls, Id.

15. Filed July 18 1916 R. E. Morris Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Accedental drowning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H R Hager Coroner
19... (Address) Pomeroy

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Am Falls — DATE OF BURIAL: 7/16 1916

20. UNDERTAKER: H R Hager — ADDRESS: Am Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

Primary Registration District No. 7072

File No. 15098

Registered No. .....

County of Power

City of Am Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME formerly Ragnhild L. Christenson Ragnhild Sophie Ray

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	White	Divorced

6. DATE OF BIRTH. August 26, 1862 (Month) (Day) (Year)

7. AGE 53 Yrs. 11 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Cook & caterss
(b) General nature of industry, business, or establishment in which employed (or employer)... Hotel

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER Oli Olsen

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Ragnhild Ray

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lillian Ray Woodhead
(Address) American Falls, Idaho

15. Filed July 29 1916 R. E. Hodnett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 28, 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1916, to July 28 1916, that I last saw her alive on July 28 1916 and that death occured on the date stated above, at 11.45 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Schulz M. D.

7/29 1916 (Address) American Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Ida	1/30 1916

20. UNDERTAKER	ADDRESS
H. R. Hager	Am Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 5072
File No. 15099
Registered No. ____

1. PLACE OF DEATH.
County of Power
City of Cameron Falls
(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W. Carmichael

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Do not know (Month) (Day) (Year)

7. AGE: 51 Yrs. about Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Deceased from nurses
(Address) at hospital.

15. Filed Aug 19 1916 — R. F. North A. C. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1916, to Aug 1916, that I last saw h[illegible] alive on Aug 18 1916, and that death occured on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of stomach and bowel.
(Duration) about Yrs. 6 mos. — ds.
Contributory (Secondary) ____ (Duration ____ yrs. ____ mos. ____ ds.

(Signed) C. F. Schuck M. D.
Aug 19 1916 (Address) Cameron Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Marysville, Mo — DATE OF BURIAL: Aug 22 1916

20. UNDERTAKER: A R Hager — ADDRESS: Cam Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 2-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 5-9

Primary Registration District No. 2139

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5-5700

Registered No. 15700

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Blaine

City of .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Angelina Drake Pierce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 6 (Month) 5 (Day) 1857 (Year)

7. AGE: 59 Yrs. 1 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Don't know

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. D. Pierce

(Address) Grouse, Idaho

15.

Filed ..... 191..

E. W. Fox
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191.. to 191.., that I last saw h.. alive on death 191.., and that death occured on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:

Carcinoma stomach
Dr E. Libs — Dull Sharp
Judy Berg

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

7/14 1916 (Signed) E. W. Fox M. D.

(Address) Arco, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arco Idaho — DATE OF BURIAL: 7/14th 1916

20. UNDERTAKER: A. D. Pierce — ADDRESS: Grouse, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. [redacted] No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 5-15101
Registered No. .....

1. PLACE OF DEATH.
County of [redacted]
City of .....
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida May Reese

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April 11th 1915 (Month) (Day) (Year)

7. AGE: 1 Yrs. 3 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wm W Reese

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Adelaide Matthews

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Tom W. Reese
(Address) Arco, Idaho

15. Filed 8/10 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Monday Aug 7 1916, to Aug 10 1916, that I last saw her alive on Aug 10 1916, and that death occured on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Entero-Colitis
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E W Kleinman M. D.
8/10 1916 (Address) Arco Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arco, Idaho — DATE OF BURIAL: 8/10 1916

20. UNDERTAKER: Tom Reese — ADDRESS: Arco, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2139
(No. .... St.)

File No. 57
Registered No. 15102

1. PLACE OF DEATH.
County of Blaine
City of Howe

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mark Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. August 13 1916 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 7½ ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John M. Hansen

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Edna Petersen

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John M. Hansen
(Address) Howe, Idaho.

15. Filed 8/24 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 21 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/2/ 1916, to 8/21 1916, that I last saw h.im alive on 8/2/ 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Premature – 7 mos
Convulsions

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

8/21 1916 (Signed) [signature] M. D.
(Address) Howe, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Howe Idaho — DATE OF BURIAL: 8/22 1916

20. UNDERTAKER: J. M. Hansen — ADDRESS: Howe Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STAR - YORK CO., PTRS. & STRS. 24652

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15105

Registered No. .....

1. PLACE OF DEATH.

County of Clearwater Registration District No. 91

City of Ahsahka (No. ....., ... St.) Primary Registration District No. 2168

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Doyet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. not known (Month) (Day) 1895 (Year)

7. AGE: 21 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Logger
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Kuzmair Doyet

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Dragola ?

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Leo Pankovych
(Address) Elk River Idaho

15.
Filed Aug - 16 1916 Mrs. J. Dimm Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 15th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1916, to Aug 15 1916, that I last saw h alive on Aug 15 1916, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Traumatic shock caused by fractured right + left femur + lacerated gluteal muscles (Duration) ... Yrs. ... mos. 5 hrs.
Contributory (Secondary) Collapse
(Duration) ... yrs. 30 minutes mos. ... ds.
(Signed) John Dimm M. D.
19.... (Address) Elk River, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elk River Idaho — DATE OF BURIAL: Aug 16 1916

UNDERTAKER: G. Morris — ADDRESS: Elk River Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

y of Canada Dr Primary Registration District No. 1208 File No. 15106

(No. ..... St.) Registered No. 29

If death occurs away from al residence, give facts d for under special in- nation,

2. FULL NAME A. L. Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced. (Write the Word): Single

6. DATE OF BIRTH. Unknown .....191...
(Month) (Day) (Year)

7. AGE: Unknown .....Yrs .....Mos .....ds.
IF LESS than 1 day how many ..... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Machinest
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Carrie

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Benj. Smith
(Address) Payette Ida

15. Filed July 14 191 6 J. W. Cuvier Local Registrar.

Place Where Remains are to be Sent: Payette Idaho
Date of Shipment: July 15 1916.

SHIPPING UNDERTAKER
ADDRESS Glenn & Landon Firm Name Payette Ida

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. July 12 191...
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....191..., to .....191...,
that I last saw h.....alive on .....191....,
and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH was as follows: Did not die of any Contagious Disease but from Accidental as found to be

.....(Duration) .....Years .....mos.....ds.

Contributory (Secondary) .....

.....(Duration) .....Years.....mos.....ds.

(Signed) O L Barton M. D.
7-12-1916 (Address) Payette Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)
At place of death....yrs....mos....days
In the State ....yrs...mos...days

Where was disease contracted if not at place of death .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Ida
Date of Burial: July 15 1916.

20. UNDERTAKER: Glenn & Landon
Address: Payette Ida

The information on this certificate is all exact COPY of the official certificate

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15107

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 2072

Primary Registration District No. 25

County of Power

City of American Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bertha Isaac Hopful

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. (Month) 26 (Day) 1891 (Year)

7. AGE: 24 Yrs. 6 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Paxton S. D.

10. NAME OF FATHER: William Isaac

11. BIRTHPLACE OF FATHER (State or Country): South Russia

12. MAIDEN NAME OF MOTHER: Sofia Lensdmer

13. BIRTHPLACE OF MOTHER (State or Country): South Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William Isaac
(Address) American Falls

15. Filed May 8th 1916 R. F. Mock Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25th 1916, to May 6th 1916, that I last saw her alive on May 6th 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis, General

(Duration) 7 Yrs. 5 mos. ..... ds.

Contributory (Secondary) ..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Richard F. Mock M. D.

5/6 1916 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: American Falls Ida. | DATE OF BURIAL: May 8 1916

20. UNDERTAKER: Fred Beaty | ADDRESS: Am. Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2072
File No. 15108
Registered No. .....

1. PLACE OF DEATH.
County of Power
City of American Falls.
(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Adelaide Starr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. May (Month) 6 (Day) 1916 (Year)

7. AGE: 86 Yrs. 3 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.? —

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Newyork

10. NAME OF FATHER: Mr Skinner

11. BIRTHPLACE OF FATHER (State or Country): Do not Know

12. MAIDEN NAME OF MOTHER: Do not Know

13. BIRTHPLACE OF MOTHER (State or Country): Do not Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): J F Starr.
(Address): American Falls.

15. Filed May 10 1916 — K. F. Roth M.D., Local Registrar

EVANS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 18 1916, to May 6 1916, that I last saw her alive on May 6 1916, and that death occured on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows: Senile debility and Chronic Bronchitis

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration) — yrs. — mos. — ds.

(Signed) J F Starr M. D.

5/6 19 16 (Address) american Falls.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Am Falls — DATE OF BURIAL: 5/7 1916

20. UNDERTAKER: H R Hager — ADDRESS: Am Falls Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2072
File No. 15109
Registered No. .....

1. PLACE OF DEATH.
County of Power
City of Am. Falls
(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Willard Gregory

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed

6. DATE OF BIRTH: April (Month) 1 (Day) 1834 (Year)

7. AGE: 82 Yrs. 2 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Samuel Gregory

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Cynthia Blanchard

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. Gregory
(Address) Am. Falls Idaho

15. Filed June 17th 1916 Richard F Hook Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15th 1916, to June 16th 1916, that I last saw him alive on June 15th 1916, and that death occured on the date stated above, at 3P M.

The CAUSE OF DEATH* was as follows:

Dysentery, Nephritis

(Duration) 2 yrs. [illegible] mos. — ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Richard F Hook M. D.
6/18 1916 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Maquoketa Iowa
DATE OF BURIAL: 6/20 1916

20. UNDERTAKER: H R Hager
ADDRESS: Am Falls Ida

BYRNS - YORK CO., PTRS. & BDRS. 24058

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

Primary Registration District No. 2072

File No. 15110

County of County

City of American Falls, (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Justina Quatier Giedd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. January (Month) 6 (Day) 1839 (Year)

7. AGE: 77 Yrs. 5 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: - - - Quatier

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: do not know

13. BIRTHPLACE OF MOTHER (State or Country): do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Trachtigell

(Address) Am. Falls, Idaho.

15.

Filed June 20 1916

R. F. Hoskins, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 15 1916, to ..... 191..., that I last saw her alive on Apr 15 1916 and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease, (Pleural Ascites) Cephalema two months

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

6/20 1916 (Address) Richard F Hoskins Am Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: American Falls, Idaho

DATE OF BURIAL: 6/20 1916

20. UNDERTAKER: Fred Benz

ADDRESS: American Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 25

Primary Registration District No. 2072

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15111

Registered No. .....

1. PLACE OF DEATH.

County of Power

City of Am Falls

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Chrisania Langhregary

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Use only one word.): Widow

6. DATE OF BIRTH. Nov (Month) 25 (Day) 1857 (Year)

7. AGE: 59 Yrs. 7 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Adam Steingraber

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A Granger

(Address) Am Falls

15. Filed July 3 1916

H R Hagen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1916, to June 20 1916, that I last saw her alive on June 20 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Interstatial Nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Pascal T Work, M. D.

7/2 1916 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Am Falls

DATE OF BURIAL: July 7 1916

20. UNDERTAKER: H R Hagen

ADDRESS: Am Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STORE 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2872
File No. 15112
Registered No. .....

1. PLACE OF DEATH.
County of Power
City of Am Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Mary A Yalmie Strong
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married
6. DATE OF BIRTH: April (Month) 25 (Day) 1884 (Year)
7. AGE: 32 Yrs. 2 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Donald Yalmie
11. BIRTHPLACE OF FATHER (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Isabelle McCloud
13. BIRTHPLACE OF MOTHER (State or Country): Scotland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George Strong
(Address) American Falls
15. Filed July 4 1916
R. R. Worth M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 2 1916, to July 3 1916, that I last saw her alive on July 3 1916, and that death occured on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Strangulation of bowel
(Duration) ..... Yrs. ..... mos. One ds.
Contributory (Secondary) General Peritonitis
(Duration) ..... yrs. ..... mos. 3/4 ds.
(Signed) Richard F Worth M. D.
July 4 1916 (Address) American Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Soda Springs — DATE OF BURIAL: July 6 1916
20. UNDERTAKER: A R Yager — ADDRESS: Am Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 46

Primary Registration District No. 2123

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15113

Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonnock.

City of Lovell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Elvin Hinz.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Single

6. DATE OF BIRTH. Aug (Month) 16th (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Lovell, Bonnock Co, Idaho

10. NAME OF FATHER: John Hinz

11. BIRTHPLACE OF FATHER (State or Country): Wilhster, Germany

12. MAIDEN NAME OF MOTHER: Mabl Hrwlins

13. BIRTHPLACE OF MOTHER (State or Country): West Liberty Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Sept 2 1916 H G Jaeger Local Registrar

SVMB - YORK CO., PTRS. & SOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16th 1916, to Sept 1st 1916, that I last saw him alive on Sept 24th 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth, seven months in utero, Acute Indigestion

..... (Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) S. C. Harrington MD

Sept 1st 1916 (Address) Plummer Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Plummer, Idaho — DATE OF BURIAL: Sept 2nd 1916

20. UNDERTAKER: H G Jaeger — ADDRESS: Plummer, Idah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 65

Primary Registration District No. 2145

File No. 15115

County of Latah

City of near Long Jack (No. ....., St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank M Gifford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: May (Month) 5 (Day) 1841 (Year)

7. AGE: 75 yrs. 3 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nora Espy

(Address) Garfield, Wash

15. Filed Aug. 7th 1916 D. Jr. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1911., to Aug 7 1916, that I last saw him alive on Aug 4 1916, and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows: Arterio Sclerosis

(Duration) 5 yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul E Mearel M. D.

8/7 1916. (Address) Garfield Wn

*State the DISEASE CAUSING DEATH; or in deaths due to External Causes, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash — DATE OF BURIAL: Aug 9 1916

20. UNDERTAKER: E Anderson — ADDRESS: Palouse Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-[illegible]-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15116
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jurelane Melvina Saunders

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH: Oct (Month) 15th (Day) 1872 (Year)

7. AGE: 43 yrs. 10 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry business or establishment in which employed (or employer): Self

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Eli Pea

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Mahaly Melvina Pea

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L D Saunders
(Address) Potlatch Ida

15.
Filed Aug 21st 1916
D. Jr. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 8 (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-9 1916, to 8-18 1916
that I last saw her alive on 8-18 1916
and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. 14 ds.
Contributory (Secondary): Measels
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J S Ellard M. D.
8-21 1916 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Freeze
DATE OF BURIAL: Aug 22 1916

20. UNDERTAKER: E. Anderson
ADDRESS: Palouse Wash.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 8 [illegible]49

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15117

Registered No. .....

1. PLACE OF DEATH.

County of Elmore

City of .....

If death occurs away from usual residence, give facts called for under special information.

(No. Smiths Ferry St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas. E. Montrose

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 24 (Day) 1857 (Year)

7. AGE: 64 Yrs. 11 Mos. 5 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Payson Utah

10. NAME OF FATHER: Chas. M. Montrose

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Roxanna Crockett

13. BIRTHPLACE OF MOTHER (State or Country): Ann.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs F J Huggins

(Address) 101 N Jefferson St

15.

Filed Aug 30 1916

E. H. Eaton
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28 1916, to Aug 28 1916, that I last saw him alive on ✓ 191..., and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Skull fracture
+ brain injury

(Duration) Few hours

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. W. Forney M. D.

8/31 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Joplin Cemetery — DATE OF BURIAL: Aug 31 1916

20. UNDERTAKER: Schreiber & Heidenreich — ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15118

Registered No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dennis M. Carty.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. Not Obtainable (Month) (Day) 1836 (Year)

7. AGE: 80 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not Obtainable

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): E. G. Burnett
(Address): Soldiers' Home

15. Filed Aug 5 1916 — E. H. Eaton Local Registrar

STUB - YORK CO., PTG. & BOOK. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1916, to Aug 4 1916, that I last saw h... alive on Aug 3 1916, and that death occured on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Senility

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. Ascarate M. D.

8/5 19 16 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Aug 6 1916
20. UNDERTAKER	ADDRESS
Frye Summers	Boise Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 45-(18)

Primary Registration District No. 2007

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15119

Registered No. 45

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 6 Garfield Ave / St.) Bench

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME C. G. Green

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Aug. 31 1844
(Month) (Day) (Year)

7. AGE 71 Yrs. 11 Mos. 17 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER (State or Country) Ann

12. MAIDEN NAME OF MOTHER Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Ann

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C. G. Green

(Address) Boise Idaho

15. Filed Aug 16 1916 E. H. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13 1916, to Aug 13 1916, that I last saw h alive on Aug 6 1916, and that death occured on the date stated above, at 5A M.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. E. Staugh M. D.

Aug 14 1916 (Address) R. E. Staugh

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL 8/18 1916

20. UNDERTAKER Schreiber & Hidenfeldt ADDRESS Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PRTG. & BDGS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

8 46

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15120

Registered No. 42

1. PLACE OF DEATH.

County of Ada.

City of Boise

Registration District No. .....

Primary Registration District No. 2004

(No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Darwin Coykendall.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. — (Month) — (Day) 1841 (Year)

7. AGE: 75 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Veteran Civil War

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Not Obtainable

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ed. G. Burnett

(Address) Boise Idaho.

15.

Filed Aug 24 1916

E. J. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1916, to Aug. 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senile Gangrene

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Collett M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Aug 23 1916

20. UNDERTAKER: Fry & Summers C. — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., TRS. & BOS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

#47

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15121

Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada.

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9

Primary Registration District No. 2004

(No. 2½ mi N.W. Meridian)

2. FULL NAME Emmett Flack.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 29 (Day) 1915 (Year)

7. AGE: — Yrs. 7 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Milton J. Flack.

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Jessie B Damon

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J M Flack

(Address)

15. Filed Aug 23 1916 — E. F. Eaton, Local Registrar

SYMS - YORK CO., PTGS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ Aug 22 1916, to ~~1916~~, that I last saw him alive on Aug 22 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Suffocation.

Suffocated While Asleep in fd

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Clyde Ea. Summers Coroner Ada M. D.

8/23 1916 (Address) Boise Idaho Ada County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 23 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2 3 7

File No. 15122

Registered No. 48

1. PLACE OF DEATH.

County of Elmore

City of Near Regina (No. 24 Miles N. x E. of Mt Home)

If death occurs away from usual residence, give facts called for under special information. at Stover Ranch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl Geer Whetstone

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 30 (Day) 1894 (Year)

7. AGE: 21 Yrs. 11 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Student

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER Ben Whetstone

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Genevieva Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Cal

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R E Anderson

(Address) Boise Ida

15. Filed Aug 24 1916 E H Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Accidental gun shot

.....(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

.....(Duration ... yrs. ... mos. ... ds.

(Signed) H. S. Eaton M. D.

8/26/16 (Address) Leonore, Elmore Co. Mt Home, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 8/28 1916

20. UNDERTAKER: Schreiber & Siderfaden | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

#2054

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15123

Registered No. 204

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 State St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William C. Shangle

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH. Sept. 7 (Month) (Day) 1871 (Year)

7. AGE 44 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): Cement Finisher

9. BIRTHPLACE (State or Country) Neb

10. NAME OF FATHER Earl Shangle

11. BIRTHPLACE OF FATHER (State or Country) Ann.

12. MAIDEN NAME OF MOTHER Roselle Kimmmer

13. BIRTHPLACE OF MOTHER (State or Country) Ann,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed 8/30 1916

E. J. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug (Month) 29th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1916, to Aug 29 1916, that I last saw h... alive on Aug 29 1916, and that death occured on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary) Injury to Left.

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) R. C. Sturz M. D.

Aug 29 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 31 1916

20. UNDERTAKER: Schreiber & Heidenfelder — ADDRESS: Boise

SYMS - YORK CO., PTRS. & BKRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15124

Registered No. 199

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 110, East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Rogers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Not Known (Month) (Day) (Year)

7. AGE: About 60 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Lebrero

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A Schreiber

(Address) Boise

15. Filed 8/6 1916

E. A. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1916, to Aug 25 1916, that I last saw h[illegible] alive on 25 Aug 1916, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Dropsy

(Duration) [illegible] yrs. 4 mos. ..... ds.

(Signed) P. E. Lewis M. D.

Aug 26 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Co. Plat — DATE OF BURIAL: Aug 26 1916

20. UNDERTAKER: Schreiber & Lieuallen — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15125
Registered No. 198

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 1004

County of Ada

City of Boise (No. 114 Broadway St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy A Stockton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 13 (Day) 1839 (Year)

7. AGE 77 Yrs. 6 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: J. J. Harris.

11. BIRTHPLACE OF FATHER (State or Country): Kentucky.

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mollie C. Sargent

(Address) Boise Idaho

15. Filed 8/25 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 24 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1915, to Aug 22 1916, that I last saw her alive on Aug 22 191 6, and that death occured on the date stated above, at 7.30 A. M.

The CAUSE OF DEATH* was as follows:

Cancer breast

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo Calvert M. D.

8/28/16 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 27 191 6

20. UNDERTAKER: Frey & Summers — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15126

Registered No. 197

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. St. Lukes Hospital St.)

2. FULL NAME Lena V. Monroe.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 7 (Day) 1911 (Year)

7. AGE: 5 Yrs. 6 Mos. 16 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Merced Monroe.

11. BIRTHPLACE OF FATHER (State or Country): Arkansas.

12. MAIDEN NAME OF MOTHER: Maud Follett

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marcus M. Monroe

(Address) Boise Idaho

15. Filed 8/25 191 6

E. Eutton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 23rd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 23rd 1916, to Aug. 23rd 1916, that I last saw her alive on Aug. 23rd 1916, and that death occured on the date stated above, at 11:40 P.M.

The CAUSE OF DEATH* was as follows:

Septic infection from acute appendicitis — Peritonitis

(Duration) — Yrs. — mos. 3 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Taylor M. D.

Aug 25 1916. (Address) Boise Ida

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 25 191 6

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24658

Canton

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

#196

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15127

Registered No. 196

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 1516 N 15 St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johnson Frederick Maw,

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug 19 (Month) (Day) 1853 (Year)

7. AGE 63 Yrs. 0 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Johnson Maw

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Julia Thompson

13. BIRTHPLACE OF MOTHER (State or Country): E Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. F. Maw

(Address) Meridian

15. Filed 8/25 6 191 .....

E. F. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 24 (Month) (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 191 6, to Aug 24 191 6, that I last saw him alive on Aug 27 191 6, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) Mitral Regurgitation

(Duration) 1 yrs. mos. ds.

(Signed) A H Parker M. D.

19 (Address) McCarty Bld Boise Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: 8/26 191 6

20. UNDERTAKER: Fry & Summers

ADDRESS: Boise Idaho

BYMS - YORK CO., PTRS. & BDRS. 24653

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

195

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 15128

Registered No. 795

County of Ada

City of Boise (No. 1807 Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William B Kirby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct 19 1866. (Month) (Day) (Year)

7. AGE: 49 Yrs. 10 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)..... Blacksmith

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Benjaman Kirby

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Harriet M. Hackshaw

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. M. K Finch
(Address) 1807 Bannock

15. Filed 8/25 1916

E. F. Carter
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27 1916, to Aug 24 1916, that I last saw h alive on Aug 22nd 1916, and that death occured on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) R. S. Williamson M. D.

19 (Address) 824 Franklin

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 25 1916

20. UNDERTAKER: Frye Summers — ADDRESS: Boise Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15129

Registered No. 194

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 1023 Main N St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Caroline Atherton Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Mar (Month) 8 (Day) 1833 (Year)

7. AGE: 83 Yrs. 5 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Hampshire

10. NAME OF FATHER: William Atherton.

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Flint.

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Rosa Smith
(Address) Mt Home Ida

15. Filed 8/26 191 6

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1916, to Aug 23 1916, that I last saw her dead Aug 23 1916, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Probably Mitral valve rupture,

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) Dr. P. Summers M. D.

19 .... (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: Aug 27 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15130
Registered No. 195

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1805 N. 10 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Almeda McCrae Roberts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Feb (Month) 23 (Day) 1840 (Year)

7. AGE: 76 Yrs. 6 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn

10. NAME OF FATHER: Robert C. McCrae

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Jane Brooks

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jack F. Skillern
(Address) 915 Warm Spgs. Ave.

15. Filed 8/24 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 23? (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1915, to Aug 23 1916, that I last saw h. alive on Aug 22 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Dropsy caused from chronic Heart lesion

(Duration) Yrs. mos. ds.

Contributory (Secondary) Heart lesion

(Duration) yrs. mos. ds.

(Signed) John Baer M. D.

8-23 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill
DATE OF BURIAL: Aug 24 1916

20. UNDERTAKER: Gray & Summers
ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15131

Registered No. 192

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. St. Lukes Hospital St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leah J. Head.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec 29 1888 (Month) (Day) (Year)

7. AGE: 27 Yrs. 7 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): ——

9. BIRTHPLACE (State or Country): Illinois.

10. NAME OF FATHER: Jacob. Zimmerman

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable.

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C.A. Head.

(Address) Barber Idaho

15.

Filed 8/22 1916

Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1916, to Aug 21 1916, that I last saw her alive on Aug 21 1916, and that death occured on the date stated above, at 7.9 M.

The CAUSE OF DEATH* was as follows:

Ruptured Uterus, Tumor

Surgical infection

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. P. McCall M. D.

19.... (Address) Barber Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: 8/23 1916

20. UNDERTAKER: Frye & Summers Co. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
(No. 1902 No 19. St.)

File No. 15132
Registered No. 191

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ada.
City of Boise.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry C. Roles.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
(Month) (Day) 1 (Year)

7. AGE: 71 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) West Virginia

10. NAME OF FATHER: Henry Roles.

11. BIRTHPLACE OF FATHER
(State or Country) Virginia

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER
(State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. L. Roles
(Address) North Yakima Wash.

15. Filed 8/22 191 6
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 18 1916, to Aug 21 1916, that I last saw h[illegible] alive on Aug 21 1916, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy
(Duration) Yrs. mos. 7 ds.
Contributory (Secondary) Arterio-sclerosis
(Duration) yrs. mos. ds.

(Signed) Jos R. Nunnally M. D.
8/24 1916. (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: 8/24 191 6

20. UNDERTAKER: Frye & Summers Co. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. #45

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15133

Registered No. 189

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 104 East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Susie Lee Frymyer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
F	W.	Married

6. DATE OF BIRTH. Sept (Month) 15th (Day) 1870 (Year)

7. AGE 45 Yrs. 11 Mos. 4 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Little Rock, Ark

10. NAME OF FATHER ~~Lee Lee~~ Burwell Lee

11. BIRTHPLACE OF FATHER (State or Country) Ark.

12. MAIDEN NAME OF MOTHER Susie Lee

13. BIRTHPLACE OF MOTHER (State or Country) Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Velma Lee Mathews

(Address) .....

15. Filed 8/20 6 191.....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
august (Month) 19th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from aug 17 1916, to aug 19 1916, that I last saw h.er alive on aug 19 1916, and that death occured on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:

Septicaemia

.....(Duration) .....Yrs. one mos. .....ds.

Contributory (Secondary) Incomplete abortion

.....(Duration .....yrs. .....mos. .....ds.

(Signed) J. S. Springer M. D.

aug 19 1916. (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State 4 yrs. Ida mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence Cambridge Ida

19. PLACE OF BURIAL OR REMOVAL Star Idaho | DATE OF BURIAL Aug 20 1916

20. UNDERTAKER Schreiber & Sidenfaden | ADDRESS Boise

Sub Spouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. #188

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15134
Registered No. 188

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carl Bergland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Aug. (Month) (Day) 1879 (Year)

7. AGE 37 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) N. Dakota

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER (State or Country) Ann

12. MAIDEN NAME OF MOTHER Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A W Gibbs
(Address) 209 1st Boise

15. Filed 8/19 191 6 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5th 1916, to Aug 18th 1916, that I last saw h.. alive on Aug 18th 1916, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Injury - Followed by Traumatic Arthritis - Gangrene of Intestines
(Duration) Yrs. mos. 13 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A Goodfellow M. D.
Aug 19 1916 (Address) Emmett Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Boise

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Aug. 20 1916

20. UNDERTAKER: Schreiber & Lidentaler | ADDRESS: Boise

Good Friend

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

1. PLACE OF DEATH

County of Ada.

City of Boise.

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No. 1703 Mo 2d St.)

STATE OF IDAHO
BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

File No. 15135

Registered No. 186

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dean West.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. Single, Married, Widowed or Divorced. (Write the Word): Married

6. DATE OF BIRTH. March 12. 1837
(Month) (Day) (Year)

7. AGE. 75 Yrs. 4 Mos. 28 ds.

IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION.
(a) Trade, profession or partcular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): ———

9. BIRTHPLACE. (State or Country) New York.

10. NAME OF FATHER: Geo P. West.

11. BIRTHPLACE OF FATHER (State or Country): New Hampshire

12. MAIDEN NAME OF MOTHER: Helen Jackson

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Margaret Pearson
(Address): Boise Idaho

15. Filed 8/14 1916

Local Registrar.

Place Where Remains are to be Sent.

Date of Shipment ..... 191...

SHIPPING UNDERTAKER

ADDRESS ..... Firm Name .....

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 10 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1916, to Aug 8 1916; that I last saw h alive on Aug 8 1916, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH was as follows:

Chronic Nephritis

.....

.....

.....(Duration) .....Years .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration) .....Years .....mos. .....ds.

(Signed) [illegible] M. D.

Aug 14 1916 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Sucidial or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)

At place ..... In the

of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted if not at place of death .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem

Date of Burial: Aug 14 1916

20. UNDERTAKER: Fry & Summers

Address: Boise Ida.

The information on this certificate is an exact COPY of the official certificate filed at place of death.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15136
Registered No. 185

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 110 East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Claude Walker Moon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 6 (Day) 1890 (Year)

7. AGE: 26 Yrs. Aug Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Georgetown Penn.

10. NAME OF FATHER: James P Moon

11. BIRTHPLACE OF FATHER (State or Country): Norwanstore Penn

12. MAIDEN NAME OF MOTHER: Nancy L Blair

13. BIRTHPLACE OF MOTHER (State or Country): Long Savannah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P.E. Carter
(Address) Boise Idaho.

15.
Filed 8/13 19 16
E. A. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1916, to Aug 17 1916, that I last saw h[illegible] alive on Aug. 1916, and that death occured on the date stated above, at 10 a M.

The CAUSE OF DEATH* was as follows:
Gunshot wound of heart
Left pneumothorax

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) James L Bryant M. D.
8/14 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 8/14 1916

20. UNDERTAKER: Shreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

182

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 15137

Registered No. 182

(No. 2001 Hath 15th St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Helphrey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Sept (Month) 22nd (Day) 1841 (Year)

7. AGE: 74 Yrs. 10 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: George Helphrey

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Bonnett

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Paul W Helphrey
(Address) Melba, Idaho

15.
Filed 8/9 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1916, to Aug 7th 1916
that I last saw h. alive on Aug 7th 1916
and that death occured on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:
Suicide by Shooting
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) John Boeckel M. D.
8-9 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 10 1916

20. UNDERTAKER: Schreiber & Siebenpfeiffer — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

181

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15138

Registered No. 181

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 110 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Ruer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1867 (Year)

7. AGE: 49 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not Obtainable

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clyde E. Summers

(Address) Boise Idaho

15.

Filed 8/1 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 31st 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1915, to July 30 1916, that I last saw h- alive on July 30 1916, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Cirrosis Liver & Carcinoma of Stomach

(Duration) 2 Yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration ... yrs. ... mos. ... ds.

(Signed) R. E. Hunt M. D.

July 31 1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Aug 1 1916

20. UNDERTAKER: Fry & Summers

ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15140

Registered No. 21

Registration District No. 27

Primary Registration District No. 2119

1. PLACE OF DEATH.
County of Oneida
City or Village of Whitney
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred Theo. Swainston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Aug (Month) 24 (Day) 1916 (Year)

7. AGE: X Yrs. X Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Nathan Swainston

11. BIRTHPLACE OF FATHER (State or Country): Whitney

12. MAIDEN NAME OF MOTHER: Nanita R. Alder.

13. BIRTHPLACE OF MOTHER (State or Country): Logan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nathan Swainston
(Address) Whitney Idaho

15. Filed 9-4 1916 Wm. A. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24 1916, to Aug 29 1916, that I last saw him alive on Aug 29 1916, and that death occured on the date stated above, at 1 a. M.

The CAUSE OF DEATH* was as follows:
Atelectasis

(Duration) Yrs. mos. 6 ds.
Contributory (Secondary) Premature birth (at 8 mo)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Bland M. D.
9/1 1916 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Whitney — DATE OF BURIAL: Aug 30 1916

20. UNDERTAKER: None. — ADDRESS:

STAR-YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15141

Registered No. 24

1. PLACE OF DEATH.

County of Franklin

Registration District No. 27

Primary Registration District No. 2119

City of Winder Ward (No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Thurston Seamons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec. (Month) 1 (Day) 1877 (Year)

7. AGE: 43 Yrs. 8 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James Thurston

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jane Graham

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ezra J. Seamons
(Address) Preston, Idaho

15.
Filed 8-10 1916 Dr. A. R. Cutler Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1916, to Aug 9, 1916, that I last saw h[illegible] alive on Aug 9 1916, and that death occured on the date stated above, at 12:10 P.M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart

(Duration) Few minutes Yrs. mos. ds.

Contributory (Secondary) Pregnancy

(Duration yrs. 7½ mos. ds.

(Signed) Curtis Bland M. D.

8-9-1916 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pride Park Utah	Aug 11 1916
20. UNDERTAKER	ADDRESS
W. A. Gidmore	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15142

Registered No. 21

1. PLACE OF DEATH.

County of Franklin

City of Preston

(No. ....., ... St.)

Registration District No. 27

Primary Registration District No. 2119

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lydia Ann Bronson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Oct. (Month) 5th (Day) 1854 (Year)

7. AGE: Yrs. 61 Mos. 10 ds. 18

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): American Fork

10. NAME OF FATHER: John Cole

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Charlotte Jenkins

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Bronson

(Address) Preston Ida.

15. Filed 9-4 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1916, to Aug 22 1916, that I last saw her alive on Aug 22 1916, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) One Yrs. 1 mos. 2 ds.

Contributory (Secondary) ✓

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G W Slater M. D.

Aug 23 1916 (Address) Preston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191

20. UNDERTAKER W. A. Robinson | ADDRESS Preston

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 15143
Registered No. 27

1. PLACE OF DEATH.
County of Franklin
City of Preston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leland Hopkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 8 (Day) 1905 (Year)

7. AGE: 10 Yrs. 09 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home with
(b) General nature of industry, business, or establishment in which employed (or employer): parents

9. BIRTHPLACE (State or Country): Preston Idaho

10. NAME OF FATHER: Charles M. Hopkins

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Lavie E Wilde

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Charles M. Hopkins
(Address): Cleveland Idaho

15. Filed 9-4 1916. A. A. Rich Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 11 1916, to August 30 1916, that I last saw h in alive on Aug 30 1916, and that death occured on the date stated above, at 5 30 a. M.

The CAUSE OF DEATH* was as follows:
Septicaemia

(Duration) ✓ Yrs. ✓ mos. 19 ds.

Contributory (Secondary): Crushing injury

(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) G W States M. D.

Aug 31 1916. (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mound Valley Ward — DATE OF BURIAL: Sep 1 1916

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of "
City of Dayton
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ____ St.)

File No. 15144
Registered No. 25
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stella Jones Perkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 15 (Day) 1891 (Year)

7. AGE: 24 yrs. 9 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dayton

10. NAME OF FATHER: D. F. Jones

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Mary J. Miles

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. F. Jones
(Address) Dayton, Ida.

15.
Filed 9-4 1916 Dr. J. Rantz Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1916, to Aug 27 1916, that I last saw her alive on Aug 26 - 1916, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Typhoid Pneumonia

(Duration) yrs. 1 mos. 5 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Dr. C. Caldwell M. D.
Aug 28 1916 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence Dayton

19. PLACE OF BURIAL OR REMOVAL: Dayton | DATE OF BURIAL: Aug 29 1916

20. UNDERTAKER: L. A. Lindquist | ADDRESS: Logan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15145

Registered No. 19

1. PLACE OF DEATH.

County of Franklin

City of Franklin

Registration District No. 27

Primary Registration District No. 2119

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Maira Wickham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 25 (Day) 1851 (Year)

7. AGE: 65 Yrs. 9 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Kier

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Anna Maira Kier

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Wickham

(Address) Franklin Ida

15. Filed 8-8 1916 R. C. Beutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/7 1916, to 6/10 1916, that I last saw h[illegible] alive on 6/10 1916, and that death occured on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. W. Lueck M. D.

6/10 1916 (Address) Franklin Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Franklin Ida. DATE OF BURIAL: June 13 1916

20. UNDERTAKER: W. A. Skidmore ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15146

Registered No. 20

1. PLACE OF DEATH.

County of Franklin

City of Preston

(No. ....., ... St.)

Registration District No. 27

Primary Registration District No. 2119

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Keith Heber Corbridge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 13 (Day) 1903 (Year)

7. AGE: 13 Yrs. 1 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farming with his
(b) General nature of industry, business, or establishment in which employed (or employer)..... father

9. BIRTHPLACE (State or Country) Preston Idaho

10. NAME OF FATHER James H Corbridge

11. BIRTHPLACE OF FATHER (State or Country) Franklin Idaho

12. MAIDEN NAME OF MOTHER Mary A Thompson

13. BIRTHPLACE OF MOTHER (State or Country) Richmond Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James H Corbridge
(Address) Preston Idaho

15.
Filed 8-7 1916 Dr. A. B. Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
7 (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1916, to July 30 1916, that I last saw h.im alive on July 30 1916, and that death occured on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Acut Nephritis

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Diphtheria

(Duration ..... yrs. ..... mos. 6 ds.

(Signed) L. A. Caufield M. D.

Aug 2 1916 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: —

DATE OF BURIAL: 8-2 1916

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK &b., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 15147
Registered No. 21

1. PLACE OF DEATH.
County of Franclin
City of Fairview
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Elizabeth Gilbert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan. (Month) 31 (Day) 1878 (Year)

7. AGE: 38 Yrs. 6 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Joseph Cole

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER: Melinda Woodland

13. BIRTHPLACE OF MOTHER (State or Country): U S

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles Gilbert
(Address) Preston, Idaho

15. Filed 8-8 1916 D. A. Clarke Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6 1916, to Aug 7 1916, that I last saw h. Ex alive on Aug 7 1916, and that death occured on the date stated above, at 6:30a M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. 5 mos. ds.

Contributory (Secondary) Had Pneumonia Feb 1916 (Duration yrs. mos. ds.

(Signed) Curtis Bland M. D.

8-8 1916 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairview — DATE OF BURIAL: 8-9 1916

20. UNDERTAKER — ADDRESS

AYMS - YORK CO., PTRS. & SONS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15148

Registered No. 22

1. PLACE OF DEATH.

County of Franklin

City of Preston

(No. ....., ... St.)

Registration District No. 27

Primary Registration District No. 2119

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Abram M. Frexler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 14 (Day) 1842 (Year)

7. AGE: 74 Yrs. 6 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wholesale Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York City

10. NAME OF FATHER: Abram M. Frexel

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Sarah McEntire Frexler Unknown

13. BIRTHPLACE OF MOTHER (State or Country): New York &

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs J. H. Koford Jr.
(Address) Preston Idaho.

15. Filed 8-9 1916 Dr. A R Cutler Local Registrar

BYRNS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/1 1916, to Aug 9 1916, that I last saw him alive on Aug 6 1916, and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Carcinoma - Left Stomach at Pylorus
Cachexia

(Duration) 7 Yrs. - mos. 21 ds.

Contributory (Secondary) Paralysis for 2 years

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A R Cutler M. D.

8/9 1916. (Address) Preston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weston Idaho — DATE OF BURIAL: Aug. 10 1916

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. Aspinall Hospital St.)

File No. 15149
Registered No. 152
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gainford Weigand

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: August (Month) 18 (Day) 1916 (Year)

7. AGE: ... yrs. ... mos. 9 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry *business, or dstablishment in* which employed (or employer) .....

9. BIRTHPLACE (State or Country) Moscow Idaho

10. NAME OF FATHER Herman A Weigand

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Alice G. Weinman

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herman A Weigand
(Address) Cottonwood Ida

15. Filed Aug 28 1916 J. F. Rice Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1916 to Aug 27 1916, that I last saw h[illegible] alive on Aug 26 1916 and that death occurred on the date stated above, at 7 30 M.

The CAUSE OF DEATH* was as follows:
Manitus

(Duration) ... yrs. ... mos. 7 ds.

Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) Joseph Aspinall M. D.
Aug 28 1916 (Address) Moscow Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 9 days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: August 28 1916

20. UNDERTAKER: Glen Price | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. County Home St.)

File No. 15150
Registered No. 54
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME S. D. Callum

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH
(Month) (Day) 18[illegible] (Year)

7. AGE 86 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) America

10. NAME OF FATHER Not given

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Milton Frazee
(Address) Moscow Superintendent Co Home

15. Filed Sept 3 1916 J. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 2 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27 1916, to Sept 2 1916, that I last saw h[illegible] alive on Aug 30 1916, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Senile Gangrene

(Duration) yrs. 3 mos. ds.

Contributory (Secondary) .....
(Duration) yrs. mos. ds.

(Signed) W. H. Cantwell M. D.
Sept 3 1916 (Address) Moscow, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence Kendrick

19. PLACE OF BURIAL OR REMOVAL Moscow | DATE OF BURIAL Sept 4th 1916

20. UNDERTAKER Glen Price | ADDRESS Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15151

Registered No. 53

Registration District No. 67

Primary Registration District No. 1011

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Moscow

2. FULL NAME Charley Simpson Taylor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.

May (Month) 25th (Day) 1867 (Year)

7. AGE

49 Yrs. [illegible] Mos. [illegible] ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) farmer

9. BIRTHPLACE

(State or Country) Iowa

10. NAME OF FATHER: B. F. Taylor

11. BIRTHPLACE OF FATHER

(State or Country) Ohio

12. MAIDEN NAME OF MOTHER: Judith Bradley

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida M. Taylor

(Address) Moscow Ida

15. Filed Aug 26 1916

D. P. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 10, 1916, to Aug. 24 1916, that I last saw h[illegible] alive on August 24 1916, and that death occured on the date stated above, at 10:55 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.

8/25 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 12 days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pullman Wash. DATE OF BURIAL: Aug 26 1916

20. UNDERTAKER: Glen Grill ADDRESS: Moscow

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 15152
Registered No. 320

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. 224 N Jefferson St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Samuel Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Oct (Month) 12 (Day) 1913 (Year)

7. AGE 2 Yrs. 10 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) British Columbia

10. NAME OF FATHER James R. Jones

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Rosa Schultz

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James R Jones
(Address) Moscow Idaho

15. Filed Aug 24 1916 — S. F. Race, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3rd 1916, to Aug 23 1916, that I last saw him alive on Aug 23 1916, and that death occured on the date stated above, at 9.30A M.

The CAUSE OF DEATH* was as follows:
Tubercular Meningitis

(Duration) Yrs. mos. 20 ds.
Contributory (Secondary) Preceding pneumonia & whooping cough
(Duration) yrs. 1 mos. 10 ds.
(Signed) F. M. Leitch M. D.
19 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho — DATE OF BURIAL: Aug 24 1916

20. UNDERTAKER: Glen Price — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRUS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 61

Primary Registration District No. 1011

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15153

Registered No. 57

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rachel Matilda Morgaredge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 22 (Day) 1846 (Year)

7. AGE: 70 Yrs. 3 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Warren J Marquis

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elizabath Scoggins

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. F. Morgaredge
(Address) Moscow

15. Filed Aug 16 1916 — D F Rue, Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1916, to Aug 15 1916, that I last saw her alive on Aug 13 1916, and that death occured on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:
Paralysis Agitans

(Duration) 6 yr 7 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Fracture of Femur and old age
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Clarke M. D.
8-16-1916 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Aug 16 1916

20. UNDERTAKER: Glen Grice — ADDRESS: Moscow

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15154

Registered No. 8

1. PLACE OF DEATH.

County of Washington — Registration District No. 86

City of Weiser — Primary Registration District No. 1010

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Belle Johnard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Apr. (Month) 16 (Day) 1877 (Year)

7. AGE: 39 Yrs. 5 Mos. 5 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John F Coats

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Mary Burr.

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur H Johnard

(Address) Weiser Idaho

15.

Filed 8-21 1916 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1916, to 8-20 1916, that I last saw her alive on 8-14 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix
& extension to Rectum and Bladder.

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Exhaustion

(Duration ..... yrs. 5 mos. ..... ds.

(Signed) Grant O. Tenney M. D.

8/21 1916 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho — DATE OF BURIAL: 8-20-1916

20. UNDERTAKER: Jos Kane & McCann — ADDRESS: Weiser Idg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 86
Primary Registration District No. 1010
File No. 15155
Registered No. 9

County of Washington
City of Weiser,
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carter Scrivner,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White,

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced,

6. DATE OF BIRTH. ----------
(Month) (Day) 1 (Year)

7. AGE: About, 28 Years.
.....Yrs.....Mos.....ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Dredge Boat Worker,
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) ----------

10. NAME OF FATHER ----------

11. BIRTHPLACE OF FATHER
(State or Country) ----------

12. MAIDEN NAME OF MOTHER --- - ----------

13. BIRTHPLACE OF MOTHER
(State or Country) ----------

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas P Klassen.
(Address) Weiser Idaho.

15.
Filed 8-24 1916 W. P. Hamilton
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August, 19 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ------- 191--, to ---------- 191....., that I last saw h-- alive on ------- 191.... and that death occured on the date stated above, at 12.05 am.

The CAUSE OF DEATH* was as follows:
Gun shotmade by H&ARevolver calibre 32,Double action by the hand of David Kramer. Weiser Washington Co. on the 18th. of Aug. 1916
.....(Duration) .....Yrs.....mos.....ds.

Contributory ----------
(Secondary)
-- --- Duration --- yrs. -- mos. --- ds.

(Signed) James J McCann Coroner
8/21 1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho — DATE OF BURIAL: Aug 23 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 15156
Registered No. 5-

1. PLACE OF DEATH.
County of Washington
City of Weiser
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carnesda A. Sanders

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. November 30 (Month) (Day) 1838 (Year)

7. AGE: 85 Yrs. 7 Mos. 11 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: William Pender

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Poline Price

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C D Dennison
(Address) Weiser Ida

15.
Filed 8-12 1916 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h— alive on — 191...
and that death occured on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Senility died Before
Dr Arrived at
Residence
(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration ... yrs. ... mos. ... ds.

(Signed) Jas J. McCann Coroner M. D.
19... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: Aug 12 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 1010

(No. ....., ... St.)

File No. 15157

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred States

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 16 (Day) 1895 (Year)

7. AGE: 21 Yrs. — Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: H L. States

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Hattie Castle

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. L. States

(Address) Cambridge Ida

15.

Filed 8-18 1916 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 8 1916, to August 17 1916, that I last saw him alive on August 16 1916, and that death occured on the date stated above, at 9:00 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculas Pertonitis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Obstruction of Bowel

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) James A Young M. D.

19 16 (Address) Weiser Ida

Aug 17

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos...9.days

Where was disease contracted if not at place of death? —

Former or usual residence Cambridge Ida

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida — DATE OF BURIAL: 8/18 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 15158
Registered No. 16

1. PLACE OF DEATH.
County of Washington
City of Weiser
(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mamie Etta Erickson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June 24 (Month) (Day) 1914 (Year)

7. AGE: ..... Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Andy Erickson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Emma Jane Rambo

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Andy Erickson
(Address) Weiser Idaho

15. Filed August 24 1917 — W. R. Hamilton — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 26 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1916, to May 26 1916, that I last saw h[illegible] alive on Aug 26 1916 and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows: Acute Milk Infection.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.

..... 19..... (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Galloway Cemetery — DATE OF BURIAL: Aug 27 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 86

Primary Registration District No. 2112

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15159

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Weiser

If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

2. FULL NAME Orrill DeShazer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 1 Yrs. 9 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Washington Co. Idaho

10. NAME OF FATHER Everett DeShazer

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mathias Hofsommer

(Address) Weiser

15. Filed 8-10 1916 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to ... 191..., that I last saw h— alive on ... 191..., and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Drowning in Irrigation ditch / Accidental

— (Duration) — Yrs. — mos. ..... ds.

Contributory (Secondary) .....

(Duration ... yrs. ... mos. ... ds.

(Signed) Jas. T. McCann Coroner M. D.

8/10 1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Cemetery — DATE OF BURIAL: Aug 10 1916

20. UNDERTAKER: G. G. Cordelle — ADDRESS: Weiser

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 86

County of Washington

Primary Registration District No. 2112

File No. 15160

City of Weiser (No. ....., ... St.)

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herman Packer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. 12 (Month) (Day) 1894 (Year)

7. AGE: 21 Yrs. 11 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: F J Packer

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Pericilla Massie

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Malcom Packer
(Address) Weiser Ida

15. Filed 8-19 1916 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at about 4 P.M.

The CAUSE OF DEATH* was as follows:
found dead in Bed
No evidence of foul play
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jas. J. McCann Coroner M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: 8/20/1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOK. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 1001
(No. ....., ... St.)

File No. 15161
Registered No. 23
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bertie Alice Beardsley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Aug (Month) 9 (Day) 1877 (Year)

7. AGE: 38 yrs. 7 mos. 25 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Samuel Ogden

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles P. Beardsley.
(Address) Grangeville

15. Filed Aug 31 1916 G S Bucklin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 2 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1916, to Aug 2 1916, that I last saw h[er] alive on Aug 1 1916 and that death occurred on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Bucklin M. D.
8/3 1916 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. ~~PLACE OF BURIAL OR~~ REMOVAL: Missouri
DATE OF BURIAL 191

20. UNDERTAKER: E E Graham E Stanerck
ADDRESS: Grangeville

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 1001
(No. ....., ... St.)

File No. 15162
Registered No. 24
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Knight

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Don't Know (Month) 1 (Day) (Year)

7. AGE: about 66 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labourer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ontario Canada

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H Stanton
(Address) Grangeville

15. Filed Aug 31 1916 G S Brockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug [redacted] Aug (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1916, to Aug 19 1916
that I last saw him alive on Aug 18 1916
and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows: Hemorrhage of Stomach due either to Ulcer or Cancer

(Duration) unknown yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Brockton M. D.
8/31 1916 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View | DATE OF BURIAL: 8/31 1916

20. UNDERTAKER: G S Hancock | ADDRESS: Grangeville

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 6 2M.1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 15163
Registered No. 23

1. PLACE OF DEATH
County of Idaho
City or Grangeville
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Seth Loren Cowen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: September 11 1841 (Month) (Day) (Year)

7. AGE: 74 yrs. 11 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter & Contractor
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass.

10. NAME OF FATHER: Seth Cowen

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: Christena Dealer.

13. BIRTHPLACE OF MOTHER (State or Country): Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sophie Cowen Stanchfield
(Address) Grangeville Idaho.

15. Filed Aug 31 1916 G S Stocklin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16 1916 to Aug 27 1916 that I last saw h alive on Aug 27 1916 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
(Duration) about yrs. mos. 2 ds.
Contributory (Secondary) Hypertrophy of Heart
(Duration) unknown yrs. mos. ds.
(Signed) G S Stocklin M. D.
8/29 1916 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View | DATE OF BURIAL: Aug 29 1916

20. UNDERTAKER: E S Hancock | ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Mt Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181
(No. ....., ... St.)

File No. 15164
Registered No. 26
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Ward Earp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH
mar 8 1872
(Month) (Day) (Year)

7. AGE
23 yrs. 9 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Joseph Arp

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Malinda Bell Sears

13. BIRTHPLACE OF MOTHER (State or Country) Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Johnnie J. Earp
(Address) Grangeville Ida

15.
Filed Aug 31 1916 G S Stuckle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug 29 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191..., that I last saw h..... alive on ——— 191..., and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Accidental drowning

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stuckle M. D.
8/30 1916 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt Idaho	Aug 30 1916

20. UNDERTAKER	ADDRESS
E Hancock	Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Mt Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181
(No. ....., ... St.)

File No. 15165
Registered No. 27
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elbert Martin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 26 (Day) 1888 (Year)

7. AGE: 28 yrs. 1 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: John W Martin

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary J Martin

13. BIRTHPLACE OF MOTHER (State or Country): Tenesee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Williams
(Address) Mt Idaho

15. Filed Aug 31 1916 G S Stocklin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from —— 191..., to —— 191..., that I last saw h— alive on —— 191..., and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Accidental drowning

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stocklin, M. D.

8/30 1916 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt Idaho
DATE OF BURIAL: Aug 30 1916

20. UNDERTAKER: S Hancock
ADDRESS: Grangeville

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho

City of Wanguille

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103

Primary Registration District No. 2181

(No. ....., ... St.)

File No. 15166

Registered No. 28

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Not Named

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Single

6. DATE OF BIRTH (X) Aug (Month) 15 (Day) 1916 (Year)

7. AGE ..... yrs. 1 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Harpster Idaho

10. NAME OF FATHER Marion J Rupe

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Sossie Beal

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marion J Rupe

(Address) Harpster Idaho

15. Filed Sept 5 1916 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1916, to Aug 17 1916, that I last saw h[illegible] alive on Aug 15 1916, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Premature Birth

6 7 months foetus

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....

(Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.

8/17 1916 (Address) Wanguille Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Harpster	Aug 17 1916
20. UNDERTAKER	ADDRESS
None	—

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15167
Registered No.

1. PLACE OF DEATH. Registration District No.
County of Nezperce Primary Registration District No.
City of Juliaetta (No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Berry Evans

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: Jan 2 (Month) (Day) 1833 (Year)

7. AGE: 83 yrs. 11 mos. 22 ds. IF LESS than 1 day how many.....hrs. or .....min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Homer

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Evans
(Address) Juliaetta

15.
Filed June 3 1916 A. A. Roe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 30 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1916, to May 30 1916
that I last saw h alive on May 29th 1916
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Cerebral Coma

(Duration) yrs. mos. 1 ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.
(Signed) J. A. Hoyt, M. D.
6/5 1916 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Potlatch ridge DATE OF BURIAL: June 2 1916

20. UNDERTAKER: J. E. Groves ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS-VOAK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15168
Registered No.

1. PLACE OF DEATH.
County of Nezperce
City of Myrtle
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Thomas Sommar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower
6. DATE OF BIRTH: Dec (Month) 6 (Day) 1852 (Year)
7. AGE: 63 yrs. 9 mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Austria
10. NAME OF FATHER: Frank Sommar
11. BIRTHPLACE OF FATHER (State or Country): Austria
12. MAIDEN NAME OF MOTHER: Mary Janca
13. BIRTHPLACE OF MOTHER (State or Country): Austria
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Sommer
(Address) Myrtle Idaho
15.
Filed ..... 191....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. 19 (Month) (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1916, to Aug 19 1916
that I last saw h— alive on Aug 12 1916
and that death occurred on the date stated above, at 11:45 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... yrs. 1 mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John B Alley M. D.
Aug 20 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Culdesac — DATE OF BURIAL: 8/20/16 191....
20. UNDERTAKER: J E Francis — ADDRESS: Culdesac

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Hill City
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 2138
(No. ....., ... St.)

File No. 15170
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ann E Powers

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH Dec 14 1856 (Month) (Day) (Year)

7. AGE 59 yrs. 8 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Bath Co Ky.

10. NAME OF FATHER Wm Shields

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wallace Powers
(Address) Hill City Ida.

15.
Filed 8 25 1916 D O'Bryan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 24 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1916, to Aug 24 1916 that I last saw her alive on Aug 24 1916 and that death occurred on the date stated above, at 2 30 M.

The CAUSE OF DEATH* was as follows:
Pericarditis
Chronic Interstitial Nephritis
(Duration) — yrs. — mos. — ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C V Blevins M. D.
Aug 26 1916 (Address) Hill City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Hill City | DATE OF BURIAL 8-26 1916

20. UNDERTAKER Jay Maxwell | ADDRESS Fairfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 97
Primary Registration District No. 2174
File No. 15172
Registered No. .....

1. PLACE OF DEATH.
County of Nez Perce
City of Lapwai
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia L. Polly.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 18 (Day) 1857 (Year)

7. AGE: 59 Yrs. 1 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: W. H Page

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Hattie Drew.

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Jennie McCracken
(Address) Culdesac. Idaho.

15. Filed Aug. 17 1916 William H Hatch Local Registrar

BYNS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 11 1916, to Aug 17 1916, that I last saw h er alive on Aug 17 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Ruptured Gall Bladder.

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Gall Stones.

(Duration) 1 yrs. 6 mos. — ds.

(Signed) William H Hatch M. D.

8/17 1916. (Address) Lapwai. Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Albion - Wash. DATE OF BURIAL: Aug 12 1916

20. UNDERTAKER: L. B. Wann. ADDRESS: Lewiston Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15174

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Nampa

(No. ....., ... St.)

Registration District No. 7

Primary Registration District No. 1006

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cecily Alvira Azevedo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Aug (Month) 10 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... /

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER M. S. Azevedo

11. BIRTHPLACE OF FATHER (State or Country) Portugal

12. MAIDEN NAME OF MOTHER Martha Gluch

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) / Mary Azevedo

(Address) Nampa, Idaho

15. Filed Aug 15 1916 Dr R Calonge Local Registrar

Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1916, to Aug 14 1916, that I last saw h[illegible] alive on Aug 14 1916, and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Infection of liver from cold

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Murray M. D.

8/16 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Catholic

DATE OF BURIAL: 8-15 1916

20. UNDERTAKER: Jno Robinson

ADDRESS: Nampa

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 15175
Registered No. ____

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Paul F. Gaussoin.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. July (Month) 18 (Day) 1916 (Year)

7. AGE: ....Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9. BIRTHPLACE (State or Country) Nampa Idaho

10. NAME OF FATHER Chas. H. Gaussoin.

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Sarah McCarty.

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas. Gaussoin.
(Address) Nampa Ida.

15. Filed Aug 22 1916. E. Ord DeCalonge Local Registrar
By Elena Hatfield Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1916, to Aug 21 1916, that I last saw him alive on Aug 20 1916, and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Amputation —
....
....
(Duration) ....Yrs. ....mos. 6 ds.
Contributory (Secondary) Rectal Fistula.
(Duration) 2 yrs. 6 mos. ds.
(Signed) F B Smith M. D.
19.... (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death? —
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: Catholic Cemetery — DATE OF BURIAL: Aug 22 1916

20. UNDERTAKER: Hatfield & Shellabarger — ADDRESS: Nampa Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15176

Registered No. .....

Registration District No. .....

Primary Registration District No. 1006

1. PLACE OF DEATH.

County of Canyon

City of Nampa

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. H. M. Edwards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 26 (Day) 1844 (Year)

7. AGE: 72 Yrs. ..... Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Nurseryman

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Virginia

10. NAME OF FATHER William Edwards

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Susana Langwar

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose L. Edwards

(Address) Caldwell

15.

Filed Aug 19 1916 Dr D Calouge Local Registrar

By ..... Deputy

SYMS - YORK CO. CTFC. [illegible]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1916, to Aug 16 1916, that I last saw him alive on Aug 15 1916, and that death occured on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Agl. Arterio-sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. B. Smith M. D.

8/17-1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rosehill Cem

DATE OF BURIAL: 8/20 1916

20. UNDERTAKER: Robinson

ADDRESS: Nampa Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15177

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Nampa

Registration District No. .....

Primary Registration District No. 1006

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eliza J Cushman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.

January (Month) 1st (Day) 1841 (Year)

7. AGE

75 Yrs. 7 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): West Liberty, Ohio.

10. NAME OF FATHER: James Copenhaver

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Elizabeth Ochletree

13. BIRTHPLACE OF MOTHER (State or Country): W. Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. S. B. Shellabarger

(Address) 903 - 11th ave so

15.

Filed Aug 19 1916 Orrin D Calhoun Local Registrar

By ..... Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec - 1916, to Aug - 1916, that I last saw her alive on Aug - 14 - 1916, and that death occured on the date stated above, at 8:20 A.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

..... (Duration) several years. Yrs. ..... mos. ..... ds.

Contributory (Secondary) Age, & Gradual weakness

..... (Duration) 2 yrs. 6 mos. ..... ds.

(Signed) F B Smith M. D.

19.... (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerstown.	Aug 19 1916
20. UNDERTAKER	ADDRESS
S B Shellabarger	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS, DENVER 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

July 7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15179

Registered No. 22

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ....., ... St.)

2. FULL NAME Cyrus W Moore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 24 (Day) 1878 (Year)

7. AGE: 38 Yrs. — Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Geo W Moore

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Burghdurs

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W Moore

(Address) Rupert

15.

Filed 9 — 7 1916

E. H. Elmore
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 17 1916, to July 5 1916, that I last saw him alive on July 5 1916, and that death occured on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. H. Elmore M. D.

7-7 1916 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert cemetery — DATE OF BURIAL: 7 — 9 1916

20. UNDERTAKER: Ida Goodman — ADDRESS: Rupert Ida.

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Minidoka — Registration District No. 19

City of Rupert — Primary Registration District No. 2015

(No. ....., ... St.)

File No. 15180

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Miles Stowe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Feb (Month) 7 (Day) 1914 (Year)

7. AGE: ....Yrs. ....Mos. 6 ds. 24 — IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Geo Stowe

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Gay Bean

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo Stowe
(Address) Rupert Idaho

15. Filed ..... 191.....

E H Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1916, to Sept 2 1916, that I last saw h alive on Sept 2 1916, and that death occured on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
Acute Gastro Enteritis

(Duration) ....Yrs. ....mos. 7 ds.

Contributory (Secondary): Pertussis

(Duration ....yrs. 1½ mos. ....ds.

(Signed) E H Elmore M. D.

19.... (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Sept 3 1916

20. UNDERTAKER: W A Goodman — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - VOSS CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lewis

City of Wallace, R.F.D.

Registration District No. 60

Primary Registration District No. 2129

(No. ....., ... St.)

File No. 15181 (262)

Registered No. 211

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME August Yaeger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): divorced

6. DATE OF BIRTH. Feb (Month) 14 (Day) 1841 (Year)

7. AGE: 75 Yrs. 5 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: ——— Yaeger

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna Catherine Griesel

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. E. J. Goltz
(Address) Wallace Idaho

15. Filed 8/13 1916 P. E. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 11, 1916, to Aug 12 1916, that I last saw him alive on Aug 12 1916, and that death occured on the date stated above, at 12:10 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Burke M. D.

Aug 12 1916 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wa cemetery — DATE OF BURIAL: 8/13 1916

20. UNDERTAKER: Forbes Drug Co. — ADDRESS: Wa. Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORKE CO., PTRS. & STNRS. 24656

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.,

County of Lyons — Registration District No. 62 — File No. 15182

City of Ids R F D. — Primary Registration District No. 2124 — Registered No. 12

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stanley Daniels

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: Full blood negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July 10 (Month) (Day) 1912 (Year)

7. AGE: 4 Yrs. 0 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: child.

(b) General nature of industry, business, or establishment in which employed (or employer): Juliaetta, Ida

9. BIRTHPLACE (State or Country): Juliaetta Idaho.

10. NAME OF FATHER: Willie Daniels.

11. BIRTHPLACE OF FATHER (State or Country): Fort Bluff. Idaho

12. MAIDEN NAME OF MOTHER: Rena Eunyan.

13. BIRTHPLACE OF MOTHER (State or Country): Juliaetta Idah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) + Thomas Beall

(Address) Ids. Idaho.

15. Filed 8/9 1916. R C Dunlop M D Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1916, to Aug 8 1916, that I last saw him alive on July 17 1916 and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Yrs. 9 mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. C. Dunlop M D M. D.

8/9 1916 (Address) Ids, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Juliaetta Idaho. DATE OF BURIAL: 8/11 1916

20. UNDERTAKER: Thomas Beall ADDRESS: Ids Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 60

Primary Registration District No. 2129

File No. 15183

Registered No. 13

County of Lewis

City of Ilo

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosetta S. Liffe Furrow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. June (Month) 3 (Day) 1893 (Year)

7. AGE: 23 Yrs. 2 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Adam Sliffe.

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Ida Brenton

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. D. J. Furrow
(Address) Lapwai Idaho

15. Filed 9/1 1916 R. E. Dunlap Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from —— 191..., to —— 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Suicide by Strychnine Poisoning

five minutes

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Gastro Enteritis

(Duration) ... yrs. ... mos. 3 ds.

(Signed) J. J. Jones M. D.

9-1 1916 (Address) Nez Perce, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I O O F Cemetery — DATE OF BURIAL: 9/3 1916

20. UNDERTAKER: Starr Hdw & Furn Co. — ADDRESS: Ilo, Idaho

BYNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2155
File No. 15184
Registered No. 906

1. PLACE OF DEATH.

County of Bonner
City of Sandpoint (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Snyder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. 7 (Month) 12 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 2 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sandpoint

10. NAME OF FATHER H. E. Snyder

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. H. Brady
(Address) .....

15.
Filed July 13 1916 M McKinnon Local Registrar

STAR - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth 7-12 1916, to 7-13 1916, that I last saw her alive on 7-13 1916, and that death occured on the date stated above, at 1.30 P M.

The CAUSE OF DEATH* was as follows:
Heart failure

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Brockaway M. D.
9/8 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: July 17 1916

20. UNDERTAKER: C. M. Brown — ADDRESS: [illegible]

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Judson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15185

Registered No. 907

1. PLACE OF DEATH.

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2135

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Boulware

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec (Month) 6 (Day) 1847 (Year)

7. AGE: 68 Yrs. 7 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Daniel Boulware

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Boulware

(Address) Sandpoint

15. Filed July 30 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to July 30 1916, that I last saw him alive on July 30 1916, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Tabes Mesenterica

..... (Duration) ..... Yrs. Several mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R W Jackson M. D.

19.... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: Augt 1916

20. UNDERTAKER: E M Brown — ADDRESS: .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNS - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15186

Registered No. 708

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 7 8 [illegible]

Primary Registration District No. 2 1 3 5

County of Bonner

City of Sandpoint (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura Elizabeth Howe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 4 (Day) 1899 (Year)

7. AGE: 16 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: N. T. Howe.

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Margie S Swan

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H T Howe
(Address) Sandpoint Rt 1

15.
Filed Aug 2 1916 M McKinnon
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26 1916, to July 31 1916, that I last saw her alive on July 31 1916, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Intestinal Stasis following accidental Gun Shot wound of abdomen

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.

Aug 1 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Colburn Cemetery — DATE OF BURIAL: Aug 3 1916

20. UNDERTAKER: E M Brown — ADDRESS: S P

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 78 Page
Primary Registration District No. 215-5

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15187
Registered No. 902

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leroy Armstrong

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: About 40 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer)... —

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E M Brower
(Address) C.O.

15.
Filed Aug 4 191 6 M McKinnon
Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 3 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21, 1916, to Aug 3 1916, that I last saw h[illegible] alive on Aug 2 1916, and that death occured on the date stated above, at 2 a. M.

The CAUSE OF DEATH* was as follows:
Interstitial nephritis.

..... (Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) ✓
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) A. F. Payne M. D.
19..... (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho | DATE OF BURIAL: 8/5 1916

20. UNDERTAKER: E M Brower | ADDRESS: S.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78 W
Primary Registration District No. 9105
(No. ....., ... St.)

File No. 15188
Registered No. 910

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cristena Sundeen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec (Month) 5 (Day) 1861 (Year)

7. AGE: 54 Yrs. 8 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Andrew Westberg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Oscar W Sundeen
(Address) .....

15. Filed Aug 7 191[illegible] M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1916, to Aug 4 1916, that I last saw her alive on Aug 4 1916, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows: Cha Angina Pectoris

(Duration) Odtwo Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chron Heart-disease
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.
Aug 6 1916 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida — DATE OF BURIAL: 8/10 1916

20. UNDERTAKER: E M Brown — ADDRESS: S. P.

SYMS - YORK CO., PTRS. & ENGS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78 Jack
Primary Registration District No. 2153
(No. .... St.)

File No. 15189
Registered No. 911

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Frank Hurbert Meeks
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 23 (Day) 1907 (Year)

7. AGE: 9 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nashy

10. NAME OF FATHER: T. L. Meeks

11. BIRTHPLACE OF FATHER (State or Country): Nebr.

12. MAIDEN NAME OF MOTHER: Leonia Marion Deitz

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) T. L. Meeks
(Address) Pandora Idaho

15.
Filed Aug 12 1916 M McKinnon
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191 , to Aug 11 1916 , that I last saw h in dead alive on Aug 11 1916 , and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Drowned
15 minutes
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. J. Jackson M. D.
19 ..... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho
DATE OF BURIAL: Aug 13 1916

20. UNDERTAKER: E M Brown
ADDRESS: Sandpoint

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock

City of Soda Springs

Registration District No. 11

Primary Registration District No. 2048

(No. ....., ... St.)

File No. 15190

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Paulo Ettorisi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.)

6. DATE OF BIRTH. Dont Know (Month) ..... (Day) 1 (Year)

7. AGE About 22 ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Shepherder

9. BIRTHPLACE (State or Country) Spanish

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eric Kardy

(Address) Soda Springs Id

15.

Filed Sep 10 1916 Eric Kardy Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep. (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 8 1916, to Sep 8 1916, that I last saw h in alive on Sep 8 1916, and that death occured on the date stated above, at 50 M.

The CAUSE OF DEATH* was as follows:

Hydrothorax

..... (Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Eric Kardy M. D.

Sep 10 1916 (Address) Soda Springs, Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Soda Springs — DATE OF BURIAL Sep 10 1916

20. UNDERTAKER None — ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15192
Registered No. 35

1. PLACE OF DEATH.
County of Bannock
City of Soda Springs
(No. ....., ... St.)

Registration District No. .....
Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hyrum G. Winters

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 27 (Day) 1862 (Year)

7. AGE: 54 yrs. 3 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Book Keeper
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thos Winters

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Johanna Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emily J. Winters
(Address) Salt Lake City

15.
Filed ..... 191...
Ellis Rackley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Sept 5 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1916, to Sept 4 1916, that I last saw h... alive on Sept 4 1916 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Hemorrhage of Bowels

..... (Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Cerebral Sclerosis
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ellen Carey M. D.
Sept 5 1916 (Address) Soda Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utah
DATE OF BURIAL: Sept 8 1916

20. UNDERTAKER: F. M. Williams
ADDRESS: Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonner

City of Bench

Registration District No. 11

Primary Registration District No. 2048

(No. ....., ... St.)

File No. 15193

Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hans Sorensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. July (Month) 1 (Day) 1837 (Year)

7. AGE: 78 Yrs. — Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Hans Hansen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Dorothea Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Mickelsen

(Address) Bench

15. Filed Aug 10, 1916 — Eric Carley, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1914 1914, to July 27 1916, that I last saw him alive on June 30, 1916, and that death occured on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Mitral)

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary): None

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Eric Carley M. D.

Aug. 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: July 29 1916

20. UNDERTAKER: None — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 15194
Registered No. 24

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. Carson apts. Idaho st St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francis Ripley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 28 (Day) 1916 (Year)

7. AGE: ....Yrs....Mos. 2 ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Harry E Ripley

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Zella Cox.

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry E Ripley
(Address) Blackfoot Idaho

15.
Filed Apr 30 1916
W E Pattie
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28 1916, to April 30 1916, that I last saw h alive on April 30 1916, and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:
Immediate Cause Pneumonia
Antecedent Cause
Morbid Conditions
(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
(Duration ....yrs....mos....ds.
(Signed) W Stevenson M. D.
4/30 1916 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fern City Cemetery — DATE OF BURIAL 191

20. UNDERTAKER: E F Peck — ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ....., ... St.)

File No. 15195
Registered No. 20

1. PLACE OF DEATH.
County of Bingham
City of Basin Canal

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed Jensen

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S.

6. DATE OF BIRTH. June (Month) 13 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 2 hrs. or 20 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Bingham Co Idaho

10. NAME OF FATHER Hans Jensen

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Martha Rasmussen

13. BIRTHPLACE OF MOTHER (State or Country) Box Elder Co Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hans Jensen
(Address) Blue Lake Post Office

15. Filed June 13 1916 M. E. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 13 (Day) 1916 (Year)

17. I ~~HEREBY CERTIFY~~, That I ~~attended deceased from~~ from birth until death, 1916, to ..... 1916, ~~that I last saw him alive on~~ ..... 1916, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Premature
(7 Mo)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) M. E. Parker M. D.
1916 (Address) Rural Bingham

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Farm of Hans Jensen — DATE OF BURIAL: June 1916

UNDERTAKER: Hans Jensen — ADDRESS: R 3

SYMS - YORK CO., PTRS. & ENGS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15196

Registered No. 38

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

County of Bingham

City of Maulard (No. Maulard St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Farnsworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	Single

6. DATE OF BIRTH. April (Month) 21 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 7 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Maulard Idaho

10. NAME OF FATHER Rodney Farnsworth

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Bulah Allyn

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Merkley

(Address) .....

15. Filed May 14 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21 1916, to May 13 1916, that I last saw her alive on May 13 1916, and that death occured on the date stated above, at 6P M.

The CAUSE OF DEATH* was as follows:

Open Foramen Ovale, an Premature Development of Heart.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E J Parkinson M. D.

5/14 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Maulard Idaho	May 14 1916
20. UNDERTAKER E J Park	ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1519

Registered No. 53

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

(No. Cty Limits St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jay Earl Gibson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 10 (Day) 1911 (Year)

7. AGE: Yrs. 3 Mos. 29 ds.

IF LESS than 1 day how many ~~hrs. or~~ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot Ida

10. NAME OF FATHER: Earl Gibson

11. BIRTHPLACE OF FATHER (State or Country): Georgia

12. MAIDEN NAME OF MOTHER: Acuma George

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl Gibson

(Address) Blackfoot Ida

15. Filed July 10 1916

M. E. Patrick
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9 1916, to July 9 1916, that I last saw him alive on July 9 1916, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Oedema Glottis

(Duration) — Yrs. — mos. 1 ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) D B Dennis M. D.

July 10 1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gem City Cemetery — DATE OF BURIAL: July 10 1916

20. UNDERTAKER: Earl Gibson — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15198

Registered No. 37

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

County of Bingham

City of Blackfoot (No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alvin Mitchell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May 10 (Month) 1916 (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bingham Co Idaho

10. NAME OF FATHER Thos. O. Mitchell

11. BIRTHPLACE OF FATHER (State or Country) Tanner Utah

12. MAIDEN NAME OF MOTHER Jane Henderson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos O Mitchell

(Address) Blackfoot Idaho

15. Filed May 11 1916

M. E. Patrie
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 10 6 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 191 6 to ..... 191 ....., that I last saw h..... alive on ..... 191 ....., and that death occured on the date stated above, at 6.00 A.M.

The CAUSE OF DEATH* was as follows:

Congenital Premature debility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) M. E. Patrie M. D.

19..... (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fort Lemhi Ferry — DATE OF BURIAL: May 11 191 6

20. UNDERTAKER: Thos O Mitchell — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOK. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 15199
Registered No. 36

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amelia Mitchell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May 10 1916 (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER Thos O. Mitchell

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Jane Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas O Mitchell
(Address) Blackfoot Route 4

15. Filed May 11 1916 W E Dietz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 10 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...
and that death occured on the date stated above, at 9:30 P. M.
The CAUSE OF DEATH* was as follows:
Convulsions and
Premature delivery
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. E. Dietz M. D.
19.... (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ranch F. F. Dubois — DATE OF BURIAL: May 11 1916
20. UNDERTAKER: Thomas O Mitchell — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 15200
Registered No. 19

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. 537 No Main Street St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed Lindsay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH. March 29 (Month) (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot Ida

10. NAME OF FATHER: Ezra Lindsay

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Mary Steers

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ezra Lindsay
(Address) Blackfoot Ida

15. Filed April 6 1916 M. E. Hadley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7 1916, to Apr 6 1916, that I last saw him alive on April 5 1916, and that death occured on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Premature Infant
6½ mos

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Davis M. D.
4/6 1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iona City Cem — DATE OF BURIAL: April 6 1916

20. UNDERTAKER: Ezra Lindsay — ADDRESS: Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ROMS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ..... St.)

File No. 15201
Registered No. 43

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agnes Mariam Steers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 19 (Day) 1915 (Year)

7. AGE: ..... Yrs. 11 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank B. Steers

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Phoebe Ison

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank B Steers
(Address) Blackfoot R. #4 Box 70

15. Filed June 2 1916
W. E. Lutie
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1916 to June 2 1916, that I last saw her alive on June 2 1916, and that death occured on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — Yrs. — mos. 3 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Beck M. D.
6/3 1916 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moreland Idaho — DATE OF BURIAL: June 3 1916

20. UNDERTAKER: A. A. Benson — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15203

Registered No. 3-7

Registration District No. 12

Primary Registration District No. 2194

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

(No. Blackfoot RFD 2 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Edward Moody

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. July (Month) 24 (Day) 1916 (Year)

7. AGE ... Yrs. ... Mos. 2 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wm. Edward Moody

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Elma Twiggs

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johnny Twiggs

(Address) Blackfoot Idaho R#2

15. Filed July 27 191... M. E. Patrick Local Registrar

SYMS-YORK CO., PRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1916, to July 27 1916, that I last saw him alive on July 26 1916 and that death occured on the date stated above, at 2:07 M.

The CAUSE OF DEATH* was as follows:

Prematurity

... (Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...

... (Duration ... yrs. ... mos. ... ds.

(Signed) W. W. Beck M. D.

7/27 1916. (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Thomas Cemetery | DATE OF BURIAL: July 28 1916

20. UNDERTAKER: Wm Edw Moody | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

51

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15206
Registered No. 58

1. PLACE OF DEATH. Registration District No. 121
County of Bingham Primary Registration District No. 2194
City or Blackfoot R.F.D. 1 (No. ....., ... St.)
Rose Precinct

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Norman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: 6 (Month) 28 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 30 mins ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: ~
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho as above

10. NAME OF FATHER: Dan Alma Norman

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Edith Genevieve Stewart

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dan Alma Norman
(Address) Blackfoot Ida R.F.D. 1

15. Filed Jan 28 1916 W. E. Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth 6/28 1916, to Death 6/28 1916
that I last saw her alive on 6/28 1916
and that death occurred on the date stated above, at 7.30 a M.

The CAUSE OF DEATH* was as follows:
Premature birth about 6/2 mos

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): None as far as I can learn

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. V. Corry M. D.
6/28 1916 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fem Cem County — DATE OF BURIAL: Jan 28 1916

20. UNDERTAKER: E I Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STATE-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-10-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 15207
Registered No. 344

1. PLACE OF DEATH.

County of .....
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ann Hawley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) (Day) 1843 (Year)

7. AGE: 73 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Home Keeping
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. M. Poynter
(Address) Blackfoot Idaho

15. Filed July 15 1916 M. E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13 1916, to July 13 1916, that I last saw her alive on July 13 1916, and that death occured on the date stated above, at 1.35 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. M. Poynter M. D.

19..... (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and, (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. 6 mos. ..... days. In the State. 73 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Po. on Teton & Po.

19. PLACE OF BURIAL OR REMOVAL: Clapham Cemetery — DATE OF BURIAL: July 16 1916

20. UNDERTAKER: H. D. Ferrell Supervisor — ADDRESS: Clapham

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 15208
Registered No. 35

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jehmael Lindquist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. (Month) 1 (Day) 905 (Year)

7. AGE ..\..Yrs. ..Mos. ..ds. IF LESS than 1 day how many .....hrs. or .....min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Sheepherder
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bingham Co Idaho

10. NAME OF FATHER Victor E. Lindquist

11. BIRTHPLACE OF FATHER (State or Country) Stockholm Sweden

12. MAIDEN NAME OF MOTHER Johannah N. Tiddekamp

13. BIRTHPLACE OF MOTHER (State or Country) Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Victor E Lindquist
(Address) Blackfoot Route 2

15. Filed July 26 1916 M. E. Petrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I [redacted] from ..... 191..., to ..... 191..., [redacted] alive on ..... 191..., and that death occured on the date stated above, at 3:20 P. M.

The CAUSE OF DEATH* was as follows:
Killed by lightning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. E. Petrie M. D.
July 26 1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Thomas Riverside Cem. | DATE OF BURIAL: July 28 1916

20. UNDERTAKER: Victor E Lindquist | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - WHITE CO., PTRS. & STNRS. 24858

FORM V. S. No. 6-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 15209
Registered No. 5-B

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. 356 N. Main St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wesley L. Fisher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	Married

6. DATE OF BIRTH. May (Month) 26 (Day) 1837 (Year)

7. AGE 79 Yrs. 2 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York State

10. NAME OF FATHER Samuel T Fisher

11. BIRTHPLACE OF FATHER (State or Country) New York State

12. MAIDEN NAME OF MOTHER Betsy Tremper

13. BIRTHPLACE OF MOTHER (State or Country) New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert L. Fisher
(Address) Blackfoot Ida

15. Filed July 27 1916 W. E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1916 to July 27 1916, that I last saw h[illegible] alive on July 27 1916 and that death occured on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows:

Senile Decay

(Duration) ... Yrs. ... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) F. A. Mitchell M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Fremont Cemetery — DATE OF BURIAL July 28 1916

20. UNDERTAKER E J Peck — ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS PRINT CO., PTGS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 15210
Registered No. 6 D

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. Idaho Insane Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James R Barker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH. (Month) (Day) 1860 (Year)
7. AGE: 56 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Nebr
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D Orr Porter
(Address) Blackfoot Idaho
15. Filed July 31 1916 M. E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) July (Day) 28 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 16 1916, to July 28 1916,
that I last saw him alive on July 27 1916,
and that death occured on the date stated above, at 2 A.M.
The CAUSE OF DEATH* was as follows:
Paresis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) D Orr Porter M. D.
19 ..... (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 1 mos. 10 days. In the State ..... yrs. 20 mos. ..... days
Where was disease contracted if not at place of death? Unknown
Former or usual residence Hailey Idaho

19. PLACE OF BURIAL OR REMOVAL: Buried in asylum cemetery — DATE OF BURIAL: July 31 1916
20. UNDERTAKER: G. D. Farrell Supervisor — ADDRESS: Asylum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMB - YORK CO., PTRS. & BOBB. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 15211
Registered No. 62

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot.
(No. Maryland St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Landon Watts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Nov (Month) 25 (Day) 1911 (Year)

7. AGE: 4 Yrs. 9 Mos. ds.
IF LESS than 1 day how many ...hrs. or ...min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Windsor Mo

10. NAME OF FATHER: Galen A. Benonie Watts

11. BIRTHPLACE OF FATHER (State or Country): Fullerton Iowa

12. MAIDEN NAME OF MOTHER: Etta May Graham

13. BIRTHPLACE OF MOTHER (State or Country): Mt Ayr. Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G B Watts
(Address) Blackfoot Idaho
(Maryland)

15. Filed Aug 6 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1916, to Aug 5 1916, that I last saw h alive on Aug 4 1916, and that death occured on the date stated above, at 11 30 P.M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis

(Duration) Yrs. 1 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H J Simmons M. D.
8/6 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs ...mos ...days. In the State ...yrs ...mos ...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Maryland cemetery
DATE OF BURIAL: 191

20. UNDERTAKER: Howard Bulkins
ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ..... St.)

File No. 15212
Registered No. 63

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James McCallum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7. AGE: 59 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Ireland

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER
(State or Country) Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Don Boyntes
(Address) Blackfoot Idaho

15. Filed Aug 6 1916 M E Patrick
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1916, to Aug 4th 1916, that I last saw him alive on Aug 4th 1916, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Acute Mania

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D O McBoyntes M. D.
Aug 5 1916. (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 1 mos. 16 days. In the State 30 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Gibbonville Idaho

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: 8/5 1916

20. UNDERTAKER: G. D. Ferrell — ADDRESS: Asylum

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 15213
Registered No. 64

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. RFD #3 St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary A. Scofield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. March (Month) 24 (Day) 1838 (Year)

7. AGE: 78 Yrs. 5 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer): None

9. BIRTHPLACE (State or Country): Greencastle Ind

10. NAME OF FATHER: Israel Evans

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Evilina White

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. Scofield
(Address) Salt Lake Utah

15. Filed Aug 25 1916
M. E. Tobin
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22 1916, to Aug 24 1916, that I last saw h.. alive on Aug 24 1916, and that death occured on the date stated above, at 11:35 P.M.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary) .....
.....(Duration .....yrs. .....mos. .....ds.

(Signed) A. J. Summers M. D.
8/24 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Aberdeen Idaho
DATE OF BURIAL: .....191.....

20. UNDERTAKER: E. J. Buck
ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. 1007

File No. 15214

County of Bingham

City of Blackfoot,

(No. ....., ... St.)

Registered No. 65-

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Harvey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 28 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: labor

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Dont Know

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. T. Peck Coroner

(Address) Blackfoot Idaho

15. Filed July 24 1916

M. E. Patrick
Local Registrar

BYRNS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Shock and internal hemorrhage due to gun shot wound fired from gun in hand of deputy sheriff according to verdict of coroner jury

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Blackfoot, Ida.

DATE OF BURIAL: 7/27/1916

20. UNDERTAKER: ~~E. T. Peck~~ E. T. Peck

ADDRESS: Blackfoot Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15215

Registered No. 66

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot (No. Blackfoot R.F.D. 3 St.)

Registration District No. 121

Primary Registration District No. 244

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Rhulph Mayhack

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 30 1915 (Month) (Day) (Year)

7. AGE: 1 Yrs. 4 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: G.R. Mayhack

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Hilda Miesen

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) G.R. Mayhack

15. Filed Aug 7 1916

W.E. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1916, to Aug 5 1916, that I last saw him alive on Aug 5 1916, and that death occured on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Nephrites

(Duration) Yrs. mos. 16 ds.

Contributory (Secondary): Measles

(Duration yrs. mos. 16 ds.

(Signed) F. C. Mayhack M. D.

7/5 1916 (Address) Blackfoot, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Cemetery — DATE OF BURIAL: Aug 7 1916

20. UNDERTAKER: E F Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE-BARKER CO., PTGS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 12

Primary Registration District No. 2144

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15216

Registered No. 67

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

(No. Idaho Insane Asylum St.)

2. FULL NAME Samuel Rutton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: 79 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. M. Bryant

(Address) Blackfoot Idaho

15. Filed Sept 12th 1916

M. C. Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1916, to Aug 31 1916, that I last saw him alive on Aug 31 1916, and that death occured on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Degeneration

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senile Dementia

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. M. Bryant M. D.

19 ..... (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 2 mos. 12 days. In the State 24 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Pocatello Ida

Former or usual residence Pocatello Ida

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: Sept 2 1916

20. UNDERTAKER: J. A. Burns — ADDRESS: Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 171
Primary Registration District No. 2194
File No. 15217
Registered No. 51

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. City Limits St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edwin M. Ourey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. — (Month) — (Day) 1862 (Year)
7. AGE: 54 Yrs. 4 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Wisconsin
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (State or Country) Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A E Ourey
(Address) .....
15. Filed June 16 1916 — W. E. Patrick, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 1 1916, to June 16 1916, that I last saw him alive on June 15 1916, and that death occured on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Cancer of rectum
(Duration) One Yrs. — mos. — ds.
Contributory (Secondary) .....
(Duration ... yrs. ... mos. ... ds.
(Signed) R. K. Louie M. D.
6-16 1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ferm City Cemetery — DATE OF BURIAL: June 17 1916
20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

EVANS - WEST CO., PTRS. & BDRS. 24652

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15218

Registered No. 52

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2194

(No. Blackfoot RFD 2 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sophia Petersen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Feb (Month) 13 (Day) 1846 (Year)

7. AGE: 70 Yrs. 4 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. M. Peterson

(Address) Blackfoot # 2

15. Filed Jun 19 1916

M. E. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19 1916, to June 19 1916, that I last saw her alive on June 16 1916, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Valvular Insufficiency of heart

(Duration) 2 Yrs. 3 mos. ds.

Contributory (Secondary) Chronic Bronchitis

(Duration) yrs. mos. ds.

(Signed) H. Summerhays M. D.

6/19 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thomas Rumsey — DATE OF BURIAL: Jun 21 1916

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1007 121-
Primary Registration District No. 2194
File No. 15219
Registered No. 116-

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. Blackfoot R F D 4 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Manilla Fullmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 20 (Day) 1898 (Year)

7. AGE: 17 Yrs. 9 Mos. 22 ds.
IF LESS than 1 day how many.....hrs. or .....min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Alonzo S. Fullmer

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Lucia E Perry

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alonzo S Fullmer
(Address) Blackfoot Ida R F D

15.
Filed June 9th 1916
W E Pratt
Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1916, to June 9 1916, that I last saw her alive on June 8 1916, and that death occured on the date stated above, at 8:10 P.M.

The CAUSE OF DEATH* was as follows:

Chorea

(Duration) — Yrs. 1 mos. 7 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W W Beck M. D.
6/10 1916 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grouland Idaho | DATE OF BURIAL: June 11 1916

20. UNDERTAKER: E J Peck | ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 107
File No. 15220
Registered No. 47

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. South Shelling Ave St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Christina Jorgensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single
6. DATE OF BIRTH. July 22 1841 (Month) (Day) (Year)
7. AGE: 74 Yrs. 10 Mos. 17 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Washing
9. BIRTHPLACE (State or Country) Denmark
10. NAME OF FATHER Gorgen Jorgensen
11. BIRTHPLACE OF FATHER (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Christina Sonnon
13. BIRTHPLACE OF MOTHER (State or Country) Denmark
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Niels P Jorgensen
(Address) .....
15. Filed June 10 1916 M. E. Stone Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 9 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 25 1916, to June 9 1916, that I last saw her alive on May 25 1916, and that death occured on the date stated above, at 7:00 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
.....(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. B. Davis M. D.
-10 1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burial Idaho — DATE OF BURIAL: June 12 1916
20. UNDERTAKER: N. P Jorgensen — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 146-15

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2 194

(No. ..... St.)

File No. 15221

Registered No. 178

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred B. Morgan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. June (Month) 11 (Day) 1880 (Year)

7. AGE 36 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Neb.

10. NAME OF FATHER Ignatius E. Morgan

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Nancy Cowan

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs F. B. Morgan

(Address) Blackfoot Ida.

15. Filed June 12 1916 E. E. Price Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1916, to June 11 1916, that I last saw him alive on June 1 1916, and that death occured on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix, Operation,

(Duration) - Yrs. - mos. 11 ds.

Contributory (Secondary) Tuberculosis infection

(Duration) - yrs. - mos. - ds.

(Signed) F. A. Mitchell M. D.

6/11 1916 (Address) Blackfoot Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Utica Cem. | DATE OF BURIAL 191

20. UNDERTAKER E. J. Peck | ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1067
File No. 15222
Registered No. 49

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot (No. 14 N. E. Main St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Ann Rowles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow
6. DATE OF BIRTH. June 26 1840 (Month) (Day) (Year)
7. AGE: 75 Yrs. 11 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
9. BIRTHPLACE (State or Country) Missouri
10. NAME OF FATHER Thomas Ely
11. BIRTHPLACE OF FATHER (State or Country) Missouri
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (State or Country) Missouri
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jessie Boyd.
(Address) 87 E. Alder
15. Filed June 13 1916 W. E. Patrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 13 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 11 1916, to June 13 1916, that I last saw her alive on June 12 1916, and that death occured on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Shock.
(Duration) 75 Yrs. 11 mos. 17 ds.
Contributory (Secondary) Fracture of Neck of Femur
(Duration) ..... yrs. ..... mos. 2 ds.
(Signed) F. M. Whitehead M. D.
6/13 1916 (Address) Blackfoot, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ferndale cemetery — DATE OF BURIAL: June 14 1916
20. UNDERTAKER: E. C. Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of Certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS & YORK CO., PTRS. & BOOKS. 24658

FORM V. [illegible]

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121

Primary Registration District No. 1007

File No. 15223

Registered No. 87

1. PLACE OF DEATH

County of Bingham

City of Blackfoot (No. West Bridge St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm. H. Mitchell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 12 (Day) 1854 (Year)

7. AGE: 60 Yrs. 6 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Daniel Mitchell

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm D Daniel Mitchell

(Address) Blackfoot Idaho

15. Filed May 17 1916 M. E. Lutes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1916, to May 17 1916, that I last saw him alive on May 16 1916, and that death occured on the date stated above, at 11 10 A.M.

The CAUSE OF DEATH* was as follows:

Lymph-Sarcoma

(Duration) 1 Yrs. 5 mos. — ds.

Contributory (Secondary)

(Duration — yrs. — mos. — ds.

(Signed) W D Daniel M. D.

May 17 1916. (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview Cemetery — DATE OF BURIAL: May 18 1916

20. UNDERTAKER: E F Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2194

(No. ....., ... St.)

File No. 15224

Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Victor Owen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7. AGE 29 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Don Poynter
(Address) Blackfoot Idaho

15. Filed May 21 1916 M. E. Price Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 20 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31st 1915, to May 20th 1916, that I last saw him alive on May 20th 1916, and that death occured on the date stated above, at 8 20 A.M.

The CAUSE OF DEATH* was as follows:
General Peritonitis

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Don Poynter M. D.
19 ..... (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs. 9 mos. 20 days. In the State Unknown .....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Preston Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Asylum Cemetery Blackfoot Ida	5/20/16 1916

20. UNDERTAKER Julius L Green Supervisor — ADDRESS RM 338 Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 15225
Registered No. 41

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nels Rasmussen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 65 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. M. Rogers
(Address) Blackfoot Idaho

15. Filed May 27 1916 — M. E. Dudley, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 6 1915, to May 21 1916, that I last saw h— alive on May 20 1916, and that death occured on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:
Epilepsy

(Duration) 20 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. M. Rogers M. D.
19..... (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 9 yrs. ..... mos. 19 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Ovid Idaho
Former or usual residence Ovid Idaho

19. PLACE OF BURIAL OR REMOVAL: Rose Idaho — DATE OF BURIAL ..... 191.....
UNDERTAKER: L. A. Rathbun — ADDRESS: Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Mail or Deliver This Certificate to Your Local Registrar. Not to the State Board of Health.

PLACE OF DEATH

County of Snohomish

City or Town of

Registration Dist. No. R-3 (No. , St.; Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information."]

WASHINGTON STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 15226

File No.

Registered No. 2, 3

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

FULL NAME Reese Caleb Babson

Personal and Statistical Particulars

3 Sex: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (Write the word): Single

6 Date of Birth: Sept 26 (Month) (Day), 1898 (Year)

7 Age: 17 yrs. 11 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8 Occupation
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9 Birthplace (State or country): North Dakota

PARENTS

10 Name of Father: William Reese Babson

11 Birthplace of Father (State or country): North Dakota

12 Maiden name of Mother: Margaret Stewart

13 Birthplace of Mother (State or country): Penn

14 The above is true to the best of my knowledge

(Informant) Chester Babson

(Address) Framington Wash

15 Filed 7-31-16, 191 W. E. Overlock Registrar.

Medical Certificate of Death

16 Date of Death: July 30 (Month) (Day), 1916 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1916, to July 30, 1916, that I last saw him alive on July 30, 1916, and that death occurred, on the date above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) One yrs. — mos. — ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. J. O. Leuthold M. D.

, 191 (Address) Framington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 Length of Residence (For Hospitals, Institutions, Transients, or Recent Residents)
At Place of death yrs. mos. ds. In the State yrs mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 Place of Burial or Removal: Framington — Date of Burial: Aug 1, 1916

20 Undertaker: Hemfield & Son — Address: Framington Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

File No. 15227

Registered No. 43

County of Bingham

City of Blackfoot

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rudolph M. Burrus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Oct (Month) 30 (Day) 1850 (Year)

7. AGE: 65 yrs. 6 mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): [redacted]

10. NAME OF FATHER: Henry Burrus

11. BIRTHPLACE OF FATHER (State or Country): Richmond, N. Y. New York

12. MAIDEN NAME OF MOTHER: Hulda McPherson

13. BIRTHPLACE OF MOTHER (State or Country): Dennis Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Melvin Burrus

(Address) Blackfoot, Idaho

15. Filed May 23 1916 M. E. Pence Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1916, to May 23 1916 that I last saw him alive on May 23 1916, and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mel.

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) F. C. Mitchell M. D.

5/23 1916 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland Idaho — DATE OF BURIAL: May 25 1916

20. UNDERTAKER: E. J. Peck — ADDRESS: Blackfoot Idaho

GYMS - YORK CO., PTRS. & BDRS. 19760

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-ment of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 171

Primary Registration District No. 7144

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15228

Registered No. 173

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

(No. at Asylum Ward St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet Chamberlin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7. AGE: Unknown Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. O. Poynter

(Address) Blackfoot Idaho

15.

Filed May 28 1916

W. C. Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6th 1915, to May 27 1916, that I last saw h[illegible] alive on May 27 1916, and that death occured on the date stated above, at 2 10 P.M.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(Duration) [illegible] Yrs. mos. ds.

Contributory (Secondary) Diabetes

(Duration) Unknown Yrs. mos. ds.

(Signed) D. O. Poynter M. D.

5/27 1916. (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 7 mos. days. In the State Unknown yrs. mos. days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Idaho Falls Idaho

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Idaho — DATE OF BURIAL: May 28 1916

20. UNDERTAKER: E. Peck — ADDRESS: Blackfoot

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 15229
Registered No. 44

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. North Shelby 288 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna J. Stephens
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH. Feb (Month) 16 (Day) 1879 (Year)

7. AGE: 37 Yrs. 3 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Cole Co Mo

10. NAME OF FATHER L T Stone

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Mrs - Berry -

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. B. Stephens
(Address)

15. Filed June 1st 1916 — M. E. Lewis, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cardiac Insufficiency
Probably Fatty degeneration
Investigated after death
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E E Peck M. D.
6/1 1916 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gem City Cemetery	June 2 1916
20. UNDERTAKER E F Peck	ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS-PECK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 2144

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15230

Registered No. 23

1. PLACE OF DEATH.

County of Bingham

City of East Blackfoot (Name) ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur Steffens

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 2 (Month) 3 (Day) 1865 (Year)

7. AGE 31 Yrs. 2 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... General Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Arthur Steffen

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. E. Williams Brother in Law

(Address) Blackfoot, Ida

15. Filed April 7 1916 W. B. Patrick Local Registrar

BYRNE - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1st 1916, to Apr 6th 1916, that I last saw h[illegible] alive on Apr 6 1916, and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

General Toxemia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Intestinal Toxemia due to Stomatitis

(Duration) 1 yrs. mos. 10 ds.

(Signed) C. N. Gibson M. D.

4-7 1916 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery — DATE OF BURIAL: 4-8 1916

20. UNDERTAKER: E Peck — ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2144
File No. 15231
Registered No. 53

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. Idaho Bonanza Anglum St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm L Dodge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1867 (Year)

7. AGE: 49 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ills

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Tom Boyne
(Address) Blackfoot Idaho

15. Filed April 3 1916 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 30 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 9 1916, to April 30th 1916, that I last saw him alive on April 30th 1916, and that death occured on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:
Pernicious anaemia
(Duration) Unknown Yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
(Duration) Unknown Yrs. ..... mos. ..... ds.
(Signed) Tom Boyne M. D.
5-1 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 4 yrs. 8 mos. 18 days. In the State 6 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Unknown
Former or usual residence Gooding Idaho

19. PLACE OF BURIAL OR REMOVAL: Gooding Idaho
DATE OF BURIAL 191

20. UNDERTAKER: E J Ruck
ADDRESS: Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15232

Registered No. 33

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

County of Bingham

City of Blackfoot

(No. Idaho Insane Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hugh Daugherty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Unknown (Month) 1 (Day) (Year)

7. AGE: 70 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Miner
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos Poynter

(Address) Blackfoot Idaho

15.

Filed April 25 1916 M. E. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1916, to April 24 1916, that I last saw him alive on April 23 1916, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Exhaustion - Senile Dementia

(Duration) Unknown yrs. mos. ds.

Contributory (Secondary): Alcoholism

(Duration) Unknown yrs. mos. ds.

(Signed) Thos Poynter M. D.

19 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos. 22 ds. In the State 21 yrs. ..... mos. 22 ds.

Where was Disease contracted, if not at place of death? Unknown

Former or usual residence. Salmon Idaho

19. PLACE OF BURIAL OR REMOVAL: Idaho Insane Asylum Cemetery at Blackfoot Idaho

DATE OF BURIAL: April 26th 1916

20. UNDERTAKER: Julius L Greer Supervisor

ADDRESS: Blackfoot Idaho P.O. Box 338

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2792
File No. 15233
Registered No. 20

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert J. Erps

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Married)

6. DATE OF BIRTH. June (Month) 10 (Day) 1884 (Year)

7. AGE 31 Yrs. 6 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Colorado

10. NAME OF FATHER John Erps

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Annie ——

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) [illegible]
(Address) John Erps

15. Filed April 15 1916 — W. E. Lahey, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Investigated 191..., that I last saw h... alive on ... 191..., and that death occured on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Accidental-Drowned

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....

(Duration ... yrs. ... mos. ... ds.

(Signed) J. B. Davies M. D.

4-14 1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: West Cliff Cem. — DATE OF BURIAL: 4/16 1916

20. UNDERTAKER: C. C. Dinwoodey — ADDRESS: Idaho Falls

BYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 124
Primary Registration District No. 2194
File No. 15234
Registered No. 21

1. PLACE OF DEATH.
County of Bonneville
City of Blackfoot (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Bodel Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Sept ? 1842 (Month) (Day) (Year)

7. AGE: 94 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P J Felsted
(Address) Blackfoot Ida Route 2

15. Filed April 17 1916 W E Yates Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1915 to March 20 1916, that I last saw her alive on March 20 1916, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Fracture of neck of femur left
(Duration) ..... Yrs. 6 mos. — ds.
Contributory (Secondary) "Old age"
(Duration) 2y yrs. — mos. ..... ds.
(Signed) W. E. Yates M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Thomas-Fairmont Cem. | DATE OF BURIAL: April 19 1916

20. UNDERTAKER: P J Felsted | ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. / Registration District No. 48
County of Lewis Primary Registration District No. 2127
City of Forest (No. ....., ... St.)
File No. 15235
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Selma Rudolph

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: March 19th (Month) (Day) 1916 (Year)
7. AGE: 1 yrs. 5 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Forest
10. NAME OF FATHER: Michael J. Rudolph
11. BIRTHPLACE OF FATHER (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Ada Aytch
13. BIRTHPLACE OF MOTHER (State or Country): Oregon
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. M. J. Rudolph
(Address): Forest, Idaho per J. Rudolph
15.
Filed 8-25-1916 Edna B. Rogers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. 24 (Month) (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 22 1916, to Aug. 24 1916
that I last saw her alive on Aug 24 1916
and that death occurred on the date stated above, at 4:10 P.M.
The CAUSE OF DEATH* was as follows: Accidental Septicaemia from Cut & Bruise on cheek followed 1 mo later by Abscess
(Duration) — yrs. 1 mos. 18 ds.
Contributory (Secondary) Adenitis & Pneumonia
(Duration) — yrs. — mos. 5 ds.
(Signed) J. W. Laughlin M. D.
Aug 24 1916 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Do Idaho — DATE OF BURIAL: 8-26-1916
20. UNDERTAKER: Star Mdse Co — ADDRESS: Do Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 15237
Registered No. 8

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. St. Mary's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lulu Wing

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Jan (Month) 7 (Day) 1857 (Year)

7. AGE 58 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: John Ryon

11. BIRTHPLACE OF FATHER (State or Country): Ire

12. MAIDEN NAME OF MOTHER: Anna Fox

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E W Wing
(Address) Lewiston City

15. Filed Aug 20 1916 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1916, to Aug 2 1916, that I last saw h e alive on Aug 2 1916, and that death occured on the date stated above, at 1-30 A.M.

The CAUSE OF DEATH* was as follows:
Valvular disease of heart

(Duration) not known Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) L J Perkins M. D.
8/3 1916. (Address) L J Perkins

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 8/4 1916

20. UNDERTAKER: Hasson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 15238
Registered No. 9

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ford Parker Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~ Widower

6. DATE OF BIRTH.
Sept (Month) 20 (Day) 1833 (Year)

7. AGE
82 Yrs. 11 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Canada,

10. NAME OF FATHER Joseph Holbrook,

11. BIRTHPLACE OF FATHER
(State or Country) Not known

12. MAIDEN NAME OF MOTHER
" "

13. BIRTHPLACE OF MOTHER
(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. L. Everett
(Address) Lewiston, Idaho

15.
Filed Sept 10 1916
L. D. Parker
Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
9 (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-26 1916, to 8-5 1916, that I last saw h alive on 8-6 1916, and that death occured on the date stated above, at 9:35 A.M.

The CAUSE OF DEATH* was as follows:
Bronchitis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Keller M. D.
8-6 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Paul Minn
DATE OF BURIAL 191

20. UNDERTAKER: Lassar
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9c
Primary Registration District No. 1009
File No. 15239
Registered No. 10

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston (No. Oxford Annex St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME C. J. Kenney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Don't Know

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: About 55 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION.
(a) Trade, profession or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. O. Martinson
(Address) Lewiston, Idaho

15. Filed Sept 10 1916 — J. J. Perkins, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) Aug (Day) 12 (Year) 1916

17. I HEREBY CERTIFY, That I attended deceased from May 6 1916, to Aug 12 1916, that I last saw h— alive on Aug 12 1916, and that death occured on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows: Duct Cerebral Nephritis

(Duration) 4 Yrs. mos. ds.
Contributory (Secondary) Non pernicious

(Duration yrs. mos. ds.
(Signed) John N. Alley M. D.
9-6 1916 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 8 13 1916

20. UNDERTAKER: C J Vasson — ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15240

Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

Registration District No. 9

Primary Registration District No. 1009

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Ceasar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) ..... (Day) 1892 (Year)

7. AGE: 24 Yrs. 7 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Matt Ceaser

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Doul-Kuov

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John H Vidrick
(Address) Forest Idaho

15. Filed Sept 10 1916 L Perkins Local Registrar

SYMS - YORK COUNTRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-11-1916, to 8-12-1916, that I last saw h— alive on 8-12-1916, and that death occured on the date stated above, at 7 00 M.

The CAUSE OF DEATH* was as follows:
Fracture of Spinal Cord, Dislocation of 6 vertebrae
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Injury
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) John H. Adley M. D.
8-12-1916 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 8-14-1916

20. UNDERTAKER: C J Vassar — ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1609
File No. 15241
Registered No. 12

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston (No. 701 6th Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosamond Tish

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Sept (Month) 28 (Day) 1811 (Year)

7. AGE: 74 Yrs. 10 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ohio,

10. NAME OF FATHER: R. Packard.

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: Susan Bird

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. L. McClary
(Address) Lewiston Ida

15. Filed Sept 10 1916 L. Pierce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 18 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1914, to August 13 1914, that I last saw h[illegible] alive on August 13 1914, and that death occured on the date stated above, at 12-00 M.

The CAUSE OF DEATH* was as follows:
Senile dementia
.....(Duration) ..... Yrs. 2 mos. ..... ds.
Contributory (Secondary) Exhaustion
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C W Shaffer M. D.
Aug 19 14 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ravine Wis
DATE OF BURIAL ..... 191..

20. UNDERTAKER: J Hasson
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston (No. 1000, 13th Ave. St.)

File No. 15242

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. M. Burns

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	married

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

7. AGE

5 yrs. 4 mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Steam Boat Engineer

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER J. M. Burns

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER — Munson

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J. M. Burns

(Address) Lewiston

15.

Filed Sept 10 1916 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug. 23 1916

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1915, to Aug 23 1916, that I last saw him alive on Aug 23 1916, and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Chron. Parenchymatous nephritis

(Duration) 1 yrs. 4 mos. — ds.

Contributory (Secondary) Failure of heart

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Perkins M. D.

8/24 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Lewiston Idaho | DATE OF BURIAL 8-24-1916

20. UNDERTAKER C. J. Vassar. | ADDRESS Lewiston Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15243
Registered No. 14

1. PLACE OF DEATH.
County of Lemhi
City of Salmon (No. ..... St.)
Registration District No. 96
Primary Registration District No. 1009
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Tom Wolf.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Aug (Month) 24 (Day) 1916 (Year)

7. AGE: 40 yrs. 9 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carriser
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: J. B. Wolf.

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Agnes Adams.

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. F. Harris.
(Address) .....

15.
Filed Sept 10 1916 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1916, to Aug 24 1916, that I last saw h~~im~~ alive on Aug 14 1916 and that death occurred on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:
Abdominal

..... (Duration) ..... yrs. 3 mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. F. Harris M. D.
8/24/1916 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Longston
DATE OF BURIAL: 8/24 1916

20. UNDERTAKER: L. Gorman
ADDRESS: Leadore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15244
Registered No. 15

1. PLACE OF DEATH.
County of Nez Perce
City of ~~Precinct~~

Registration District No. 95
Primary Registration District No. 1009
(No. Waha Grade St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sister Mary Rose Hodges

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... 1 (Month) (Day) (Year)

7. AGE: 38 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: School teacher
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Hodges

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mother M. Hildegard
(Address) Cottonwood Ida.

15.
Filed Sept 10. 1916 — L P Perkins, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 8 (Month) 28 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h— alive on ..... 191...
and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Auto accident
Contusion over eye

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Vassar Coroner M. D.
8/29 1916 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood
DATE OF BURIAL: 8/30 1916

20. UNDERTAKER: J. Vassar
ADDRESS: Lewiston

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. 15245
Registered No. .....

1. PLACE OF DEATH.
County of Benewah
City of St Maries

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Mitchell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Aug 16 – Aug (Month) 16 (Day) 1916 (Year)

7. AGE ..... Yrs. 0 Mos. ..... ds.
IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER Carl Mitchell

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Clarissa Kelsey

13. BIRTHPLACE OF MOTHER (State or Country) Moscow, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J C Hannerly
(Address) St Maries

15. Filed Aug 18 1916. H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...; that I last saw him alive on Aug 16 1916, and that death occured on the date stated above, at 7 P.M. The CAUSE OF DEATH* was as follows: Premature birth,

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Premature birth
.....(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. O. Platt by M. D.
8/16 1916 (Address) St Maris

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries | DATE OF BURIAL: Aug 18 1916

20. UNDERTAKER: H E Hunt | ADDRESS: St Maris

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTG. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. 15246
Registered No. .....

1. PLACE OF DEATH.
County of Bonneville
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leonard Brigham Corliss

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Sept (Month) 11th (Day) 1840 (Year)

7. AGE: 75 Yrs. 11 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Retired Civil Army Veteran

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Stephen Corliss

11. BIRTHPLACE OF FATHER (State or Country): Canada or Canaan New Hampshire

12. MAIDEN NAME OF MOTHER: Mary A. Brigham

13. BIRTHPLACE OF MOTHER (State or Country): Rutland Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Alice V. Henderson
(Address) St Maries Idaho

15.
Filed Aug 20 1916
H E Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17th 1916, to Aug 18th 1916, that I last saw h.im alive on Aug 18 1916, and that death occured on the date stated above, at 10 30 A.M.

The CAUSE OF DEATH* was as follows:
Nephritis
Oedema of Lungs & Hemorrhage internally from Stomach
(Duration) 3 mos. Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Mullinbrooks M. D.
8/20 1916 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries | DATE OF BURIAL: Aug 20 1916

20. UNDERTAKER: H E Smith | ADDRESS: St Maries

BYMS - YORK CO., PTRS. & ROSS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15247

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Benewah

City of St Maries

Registration District No 32

Primary Registration District No 2049

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen M. Cash

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 26 (Day) 1911 (Year)

7. AGE: 4 Yrs. 10 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer)... —

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: B K Cash.

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Mary M Drewett

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) B K Cash.
(Address) St Maries

15. Filed Aug 28 1916 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1916 to Aug 28 1916, that I last saw her alive on Aug 28 1916, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) — Yrs. — mos. 4 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. Kinnaline M. D.

8/28 1916. (Address) St. Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Aug 28 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St. M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15248

Registered No. .....

1. PLACE OF DEATH.

County of Benewah

City of St Maries

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown (Skeleton)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.):

6. DATE OF BIRTH. Not known (Month) (Day) 1 (Year)

7. AGE: about 45 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: Don't know

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Don't know

10. NAME OF FATHER: Don't know

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Aug 16 1916 — H E Smith, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH about April or May (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...., that I last saw h..... alive on ..... 191...., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Unknown — no way to determin it. Only a Skeleton.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C J Kinnaird M. D.

8/16 1916 (Address) St Maries Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Aug 18 1916

20. UNDERTAKER: H E Smith — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTG. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15249

Registered No. .....

1. PLACE OF DEATH.

County of Bennuah

City of St Maries

Registration District No 32

Primary Registration District No 2049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tiori Francesco.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. (Month) 18 (Day) 1892 (Year)

7. AGE: 23 Yrs. 8 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Italia

10. NAME OF FATHER Tiori Francesco.

11. BIRTHPLACE OF FATHER (State or Country) Italia

12. MAIDEN NAME OF MOTHER Ferri Maria

13. BIRTHPLACE OF MOTHER (State or Country) Italia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mike Tiori

(Address) St Maries

15. Filed Aug 8 1916

H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8 1916, to Aug 8 1916, that I last saw h im alive on Aug 8 1916, and that death occured on the date stated above, at 9:30 a M.

The CAUSE OF DEATH* was as follows:

Railroad injury
Skull fracture

(Duration) ..... Yrs. ..... mos. 30 minutes

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

8/8 19 16 (Signed) D E Cornwall M. D.

(Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Aug 9 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15250

Registered No. .....

1. PLACE OF DEATH.

County of Bennock

City of St Maries

Registration District No. 32

Primary Registration District No. 2049

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas D. Searles

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: R.R. Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ills.

10. NAME OF FATHER: Samuel W. Searles

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Melvina Archer

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C A Searles

(Address) Alberton Mont.

15. Filed Aug 6 1916 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1916, to Aug 6 1916, that I last saw h in alive on Aug 6 1916, and that death occured on the date stated above, at 9 9 M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

..... (Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. Cornwall M. D.

Aug 6 1916 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Aug 7 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTS. & BOKS. 24858

FORM V. S. No. 5-2[illegible]. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 18
Primary Registration District No. 2102
(No. ....., ... St.)

File No. 15251
Registered No. 8

1. PLACE OF DEATH.
County of Minidoka
City of Heyburn.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lloyd Emery Shinn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
June (Month) 2nd (Day) 1916. (Year)

7. AGE
..... Yrs. ..... Mos. 1½ ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... ~
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Heyburn, Ida.

10. NAME OF FATHER Arthur Shinn

11. BIRTHPLACE OF FATHER
(State or Country) Kansas

12. MAIDEN NAME OF MOTHER Mattie Stoddard

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arthur Shinn
(Address) Heyburn, Ida.

15.
Filed Sept 10 1916 O. R. Tillery
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 4th (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1916, to June 4 1916, that I last saw h[illegible] alive on June 4 1916, and that death occured on the date stated above, at 6. a. M.

The CAUSE OF DEATH* was as follows:
Premature

(Duration) ..... Yrs. ..... mos. 1½ ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
June 4 1916. (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Heyburn, Ida.
DATE OF BURIAL: June 4 1916.

20. UNDERTAKER: Home
ADDRESS: ~

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lewis.

City of Nezperce,

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 47

Primary Registration District No. 2124

(No. ....., ... St.)

File No. 15252

Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rufus Clifton Bywaters

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb. (Month) 6 (Day) 1857 (Year)

7. AGE: 59 Yrs. 5 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Robert Bywaters

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Elizabeth Bell

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sue L. Bywaters

(Address) Nezperce, Idaho

15.

Filed Aug. 15 1916 J. T. Jones Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1916, to Aug 15 1916, that I last saw him alive on Aug 15 1916, and that death occured on the date stated above, at 10.25 M.

The CAUSE OF DEATH* was as follows:

Hypertrophy Prostate
(Prostatectomy July 31)

(Duration) 8 mo. Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic nephritis

Cystitis (Duration 8 mo. yrs. ..... mos. ..... ds.

(Signed) R. E. Dwelle M. D.

8/15 1916 (Address) Ilo, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston, Idaho — DATE OF BURIAL: 8-16 1916

20. UNDERTAKER: J. P. Donovan — ADDRESS: Nezperce Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15253
Registered No. 77

1. PLACE OF DEATH.
County of Lewis
City of Nezperce
Registration District No. 47
Primary Registration District No. 2124
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Lorena Powell Earl

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH: Nov ? 1836 (Month) (Day) (Year)
7. AGE: ~~80~~ 79 yrs. 9 mos. ? ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Ill
10. NAME OF FATHER: J. M. Powell
11. BIRTHPLACE OF FATHER (State or Country): Viola Powell
12. MAIDEN NAME OF MOTHER: Smith
13. BIRTHPLACE OF MOTHER (State or Country): Not Known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L. L. Hotaling
(Address) Nezperce, Idaho
15.
Filed Aug. 26 1916 J. F. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 25 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 1915, to Aug 1916
that I last saw her alive on July 1916
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
General Senile decay
Duration ..... yrs. — mos. — ds.
Contributory Mal Nutrition
(Secondary)
Duration ..... yrs. 6 mos. — ds.
(Signed) John L. Kelly M. D.
8/25 1916 (Address) Nezperce

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nezperce, Idaho
DATE OF BURIAL: aug. 27 1916
20. UNDERTAKER: D. P. Donovan
ADDRESS: Nezperce Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE. 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boise
City of .....

Registration District No. 15
Primary Registration District No. .....
(No. ....., ... St.)

File No. 15254
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lorew Olsen

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M		

6. DATE OF BIRTH
..... (Month) ..... (Day) 1911 (Year)

7. AGE
..... yrs. 7 mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Frank Olsen

11. BIRTHPLACE OF FATHER (State or Country) Col

12. MAIDEN NAME OF MOTHER May Higgens

13. BIRTHPLACE OF MOTHER (State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Troggle
(Address) .....

15.
Filed Sept 10 1916 Ruth M. McDonald
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
7 (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-14 1916, to 7-20 1916, that I last saw h alive on 7-20 1916, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Cholera Infantum
.....
.....
..... (Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Troggle M. D.
..... 19 ..... (Address) Cascade

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Vanwyck	7-22 1916
20. UNDERTAKER	ADDRESS
.....	.....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15255

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna Catherine Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Oct (Month) 21 (Day) 1914 (Year)

7. AGE: 1 Yrs. 10 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. M. Wilson

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Lena Dressel

13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Edith Wilson
(Address): Emmett Ida

15.
Filed 9/1 1916
L. L. Reynolds
Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1916, to Aug 31 1916, that I last saw her alive on Aug 31 1916, and that death occured on the date stated above, at 7:30 a M.

The CAUSE OF DEATH* was as follows:
Ileo colitis

.....(Duration) ..... Yrs. 2 mos. 2 ds.

Contributory (Secondary): none

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. A. Cummings M. D.

8/31/1916 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho

DATE OF BURIAL: 9/1 1916

20. UNDERTAKER: C. A. Buckman

ADDRESS: Emmett Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15256

Registered No. .....

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac Henry Eagan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. June (Month) 19 (Day) 1854 (Year)

7. AGE: 61 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Leather Worker
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Wm A. Eagan

11. BIRTHPLACE OF FATHER (State or Country): Do not Know

12. MAIDEN NAME OF MOTHER: Frances Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. G. W. Farlow
(Address) Emmett Idaho

15.
Filed 8/31 1916
J. K. Reynolds Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1916, to Aug 29 1916, that I last saw h[illegible] alive on Aug 29 1916, and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis (Pulmonary)

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) B O Clark M. D.
8-31 1916 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 16 days. In the State ..... yrs. ..... mos. 16 days
Where was disease contracted if not at place of death? Nebr.
Former or usual residence Nebraska

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 8/31 1916

20. UNDERTAKER: C. D. Buckman — ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2135
File No. 15258
Registered No. 712

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Cameron

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 40 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Lumber Jack
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE —
(State or Country)

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER —
(State or Country)

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER —
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E M Brower
(Address) Sandpoint Idaho

15.
Filed Aug 21 1916 M McKinnis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 20 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W M Knowles M. D.
8/21 19 6 (Address) Naples Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Idaho	8/22 1916
20. UNDERTAKER	ADDRESS
E M Brower	S.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78 Page
Primary Registration District No. 2133
File No. 15259
Registered No. 913

1. PLACE OF DEATH.
County of Bonner
City Sandpoint
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Harbrd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 60 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer)... —

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E M Brown
(Address) .....

15.
Filed Aug 22 1916 M McKinnon
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
8 (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1916, to Aug 21 1916, that I last saw h. pm alive on Aug 20 1916, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Cirrhosis of the liver

(Duration) Unknown mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. F. Page M. D.
19.... (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Ida	8/23 1916
20. UNDERTAKER	ADDRESS
E M Brown	[illegible]

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2135
File No. 15260
Registered No. 214

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hester A Bonner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Dec. (Month) 6 (Day) 1847 (Year)

7. AGE: 68 Yrs. 8 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Hiram Stevens

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Eliza Chapman

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hiram Bonner
(Address) City -

15. Filed Aug 25 1916 M McKinnon Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1916, to Aug 24 1916, that I last saw h[illegible] alive on Aug 19 1916, and that death occured on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Arterial sclerosis
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
Aug 24 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Bonners Ferry Ida - DATE OF BURIAL: 8/27 1916

20. UNDERTAKER: E M Brown ADDRESS: S. P.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Idaho
City of Ferdinand
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 185
Primary Registration District No. 2183
(No. ..... St.)

File No. 16 15261
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Wilfrid Kuther

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1915 (Year)

7. AGE: ..... yrs. 10 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Henry J. Kuther

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Rosa Kam

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry J. Kuther
(Address) Ferdinand

15.
Filed Aug 28 1916 W. O. Black
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22 1916, to Aug 26 1916
that I last saw him alive on Aug 26 1916,
and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 6 ds.
Contributory (Secondary) Primary attack. Measles. following inoculation for spotted Fever
..... (Duration) ..... yrs. ..... mos. 10 ds.
(Signed) J. D. Shumwick M. D.
Aug 28 1916 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ferdinand
DATE OF BURIAL: Aug 29 1916

20. UNDERTAKER: A. H. Nau
ADDRESS: Cottonwood Ida

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15262

Registered No. 71

1. PLACE OF DEATH.
County of Gem
City of Emmett
(No. [illegible] St.)

Registration District No.
Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Effie St Clair

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	married

6. DATE OF BIRTH Nov (Month) 26 (Day) 1893 (Year)

7. AGE 22 yrs. 9 mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Wm J Skillings

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Rachel Arrants

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Skillings
(Address) Montour Idaho

15.
Filed Sept 9 1916 E. Vadney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st 1916, to Sept 9th 1916 that I last saw her alive on Sept 8 1916, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Gunshot Wounds
inflicted by
Nick St Clair

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) E Vadney yrs. mos. M K ds.

(Signed) C D Buckham M. D. Coroner
Sept 9 1916 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Brownlee Idaho
DATE OF BURIAL Sept 10 1916

20. UNDERTAKER C D Buckham
ADDRESS Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15263

Registered No. 15

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Elmore
City of Montour
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Dec. (Month) 10 (Day) 1852 (Year)

7. AGE: 63 yrs. 8 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Liveryman
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rochell Ill.

10. NAME OF FATHER: Harman Harrisson Talley

11. BIRTHPLACE OF FATHER (State or Country): Bloomington Delaware

12. MAIDEN NAME OF MOTHER: Hainah Smith

13. BIRTHPLACE OF MOTHER (State or Country): Zainsvill Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): C.A. Talley
(Address): Sweet Idaho

15.
Filed Sep 9 1916 E Vickery Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 - 1916, to Aug 23 1916, that I last saw h[illegible] alive on Aug 23 1916, and that death occurred on the date stated above, at 2.20 P.M.

The CAUSE OF DEATH* was as follows:
Perforating Gastric Ulcer

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) B.O. Clark M. D.
19 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Sweet Idaho
DATE OF BURIAL: 9 25 1916

20. UNDERTAKER: O.D. Bucknum
ADDRESS: Emmett

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15264
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph R. Smith.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: Sept (Month) 4 (Day) 1857 (Year)

7. AGE: 57 yrs. 11 mos. 27 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Traveling Salesman
(b) General nature of industry business or establishment in which employed (or employer): Harvesting Machinery

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Smith

11. BIRTHPLACE OF FATHER (State or Country): ~~Ohio~~ Pennsylvania

12. MAIDEN NAME OF MOTHER: Hannah Plowman

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J R Smith
(Address) Salt Lake City, Utah

15. Filed 9/11/1916 — C H Kelly Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1916, to Aug. 31 1916
that I last saw him alive on Aug. 30 1916
and that death occurred on the date stated above, at 2; AM.

The CAUSE OF DEATH* was as follows:

Operation, Ruptured Appendix.

..... (Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) Acute delitation of Heart

..... (Duration) ..... yrs. 10, min. mos. ..... ds.

(Signed) Chas E Hoffman M. D.

Aug. 31 1916 (Address) Montpelier, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 4 ds.
In the State Passing through ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? Montpelier, Idaho.
Former or usual residence. Salt Lake City, Utah.

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City, Utah
DATE OF BURIAL: Sept 2 1916

20. UNDERTAKER: F. M. Williams
ADDRESS: Montpelier, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 57
Primary Registration District No. 2136
(No. ..... St.)

File No. 15265
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bear Lake.
City of Montpelier.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gleddys N. Huff.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 13 (Day) 1892 (Year)

7. AGE: 24 Yrs. 1 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Byron. S. Nelson.

11. BIRTHPLACE OF FATHER (State or Country): Missouri.

12. MAIDEN NAME OF MOTHER: Pauline Tubbs

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. B. S. Nelson
(Address) Montpelier, Ida.

15. Filed 9/11/16 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 29, (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1916, to Aug 29 1916, that I last saw her alive on Aug 29 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Mitral regurgitation

(Duration) 3 Yrs. — mos. — ds.

Contributory (Secondary) nephritis acute

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Lyon M. D.
Aug 29 1916. (Address) Montpelier.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier, — DATE OF BURIAL: Aug 31 1916

20. UNDERTAKER: F. M. Williams. — ADDRESS: Montpelier,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24668

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
File No. 15266
Registered No.

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
If death occurs away from usual residence, give facts called for under special information.

(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christine Kahler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: January 2 1915
(Month) (Day) (Year)

7. AGE: 1 yrs. 6 mos. 29 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: David Kahler.

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Christine Schmidt

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Neuenschwander
(Address) Aberdeen Ida

15.
Filed Aug 4 1916 [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug 1 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Not known -
no Physician in attendance.
Died suddenly

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Aberdeen Ida
DATE OF BURIAL: Aug 2 1916

20. UNDERTAKER: None
ADDRESS: None

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 116

Primary Registration District No. 2195

File No. 15267

County of Bingham

City of Aberdeen (No. ....., ... St.)

Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Baumgartner

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	Married

6. DATE OF BIRTH: July (Month) 15 (Day) 1876 (Year)

7. AGE: 40 yrs. 0 mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Isaac Habeggar

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Rebecca ——

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Neuenschwander
(Address) Aberdeen Ida

15.
Filed Aug 14 1916 M. Mementhimm
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Gored to death by a bull —
No Physician in attendance
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Instantly killed
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Aberdeen Ida | DATE OF BURIAL: Aug 14 1916

20. UNDERTAKER acting: A Baumgartner | ADDRESS: Aberdeen Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2007

File No. 15268

County of Canyon

City of

(No. , St.)

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy May Carlyle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	S

6. DATE OF BIRTH: Nov (Month) 2 (Day) 1915 (Year)

7. AGE: 9 yrs. 9 mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canyon Co

10. NAME OF FATHER H C Carlyle

11. BIRTHPLACE OF FATHER (State or Country) Ida

12. MAIDEN NAME OF MOTHER Lelette E Evans

13. BIRTHPLACE OF MOTHER (State or Country) Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H.C. Carlyle
(Address) .....

15. Filed Aug 30 1916 Luhrs Haldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 29 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191... and that death occurred on the date stated above, at 7:10 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal Toxemia
See Remarks on back

~~1 week~~ (Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Luhrs Haldrop Reg. M. D.

Aug 30 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Roswell	Aug 31 1916

20. UNDERTAKER	ADDRESS
Peckham Case Co	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon — Primary Registration District No. 2005

City of Caldwell Ida. — No. ____ St.)

File No. 15269

Registered No. 62

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Henry Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March 26 (Month) (Day) 1879 (Year)

7. AGE: 37 Yrs. 5 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Brookfield Mo

10. NAME OF FATHER J M Wilson

11. BIRTHPLACE OF FATHER (State or Country) Belmont Co. Ohio

12. MAIDEN NAME OF MOTHER Bell Daily

13. BIRTHPLACE OF MOTHER (State or Country) Belmont Co Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. F. Falcon
(Address) Caldwell Idaho

Filed Sept. 9th 1916

Registered Sept. 21 1916

J. D. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Hanging himself — hanged by a rope around his neck. Placed by his own hands
..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

9/21/1916 (Signed) A. A. Faris Coroner M.D.
(Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER W. C. Dyer | ADDRESS Caldwell

IMPRINT OF YORK CO., PTRS. & BDRS. 24658

PRINTED FOR BINDING
UNFADING INK—THIS IS A PERMANENT RECORD.
should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 15270
Registered No. 61

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy Ellen Mayall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. June (Month) 23 (Day) 1832 (Year)

7. AGE: 83 Yrs. 7 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Indianna.

10. NAME OF FATHER James. Grissom.

11. BIRTHPLACE OF FATHER (State or Country) Don't know

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (State or Country) Don't know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W B Doolittle
(Address) Caldwell Idaho

15. Filed 8-15- 1916 John S. Meyer Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12- 1914, to Aug. 14- 1916,
that I last saw h.. alive on Aug 1- 1916,
and that death occured on the date stated above, at 10.30 P. M.

The CAUSE OF DEATH* was as follows:
Senality.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteriosclerosis.
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John S Meyer M. D.
8/15/1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant Ridge. DATE OF BURIAL: Aug 15 1916
20. UNDERTAKER: Pentham Care Co ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ....., ... St.)

File No. 15871
Registered No. 60

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon
City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Celestia A. Mallery.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widowed

6. DATE OF BIRTH. August (Month) 10th (Day) 1840 (Year)

7. AGE 76 Yrs. — Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Home work

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York State

10. NAME OF FATHER James W. Aldrich

11. BIRTHPLACE OF FATHER (State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Gowen

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lettie P. Askey.

(Address) Caldwell, Idaho.

15. Filed 8-14-1916 Jos. S. Meyer Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1916, to Aug 12 1916, that I last saw h.er alive on Aug 12 1916, and that death occured on the date stated above, at 1 30 P.M.

The CAUSE OF DEATH* was as follows:

Cancer Stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Stevens M. D.

8/14 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Canyon Hill. **DATE OF BURIAL** Aug 15 1916

20. UNDERTAKER Beckham Bros. **ADDRESS** Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

1. **PLACE OF DEATH.**

County of Lincoln

City of Shoshone

Registration District No. 16

Primary Registration District No. 2016

(No. ....., ... St.)

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15272

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** King B Peck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** male

4. **COLOR OR RACE** white

5. ~~SINGLE, MARRIED, WIDOWED OR DIVORCED.~~ widower (Write the word.)

6. **DATE OF BIRTH.** unknown (Month) (Day) (Year)

7. **AGE** 86 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. **BIRTHPLACE** (State or Country) Ohio

10. **NAME OF FATHER** Ebenezer Peck

11. **BIRTHPLACE OF FATHER** (State or Country) Ills

12. **MAIDEN NAME OF MOTHER** Hannah Burns

13. **BIRTHPLACE OF MOTHER** (State or Country) Ills

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.**

(Informant) W J Peck

(Address) .....

15. Filed Aug 29" 1916

J L Fuller
Local Registrar

SYMS - YORK CO., SYMS & SONS. 24853

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Aug (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1916, to Aug 27 1916, that I last saw h~~e~~ alive on Aug 27 1916, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia,

.....

.....

.....

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Age,

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) J L Fuller M. D.

Aug 28 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Shoshone — **DATE OF BURIAL** Aug 29" 1916

20. **UNDERTAKER** O J Brennan — **ADDRESS** Shoshone

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 122

Primary Registration District No. 2200

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15273

Registered No. 227

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Interstate Mine (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Busby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. X Aug (Month) 25 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Calvin Busby

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Rose Kay

13. BIRTHPLACE OF MOTHER (State or Country) West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Calvin Busby

(Address) Interstate Mine

15. Filed 8/27 1916 M Mowery Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1916, to Aug 25 1916, that I last saw him alive on Aug 25 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) ..... Yrs. ..... mos. Five ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Mowery M. D.

8/27 1916 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Wallace, Ida. DATE OF BURIAL Aug 26 1916

20. UNDERTAKER Bruce Waddell ADDRESS Wallace

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15274

Registered No. 28

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 122

Primary Registration District No. 2205

(No. Western Union Mine St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Björklund

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 55 Yrs. 4 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Jacob Björklund

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Felix Björklund

(Address) Wallace Ida.

15. Filed 8/4 1916 H. T. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. R. Mowry M. D.

19..... (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Gem Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Aug 6. 1916

20. UNDERTAKER: Ward Hud Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Stites
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1060
Primary Registration District No. 0744
(No. ....., ... St.)

File No. 15275
Registered No. 45
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hiram D Brundige

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 9th (Day) 1852 (Year)

7. AGE: 63 yrs. 6 mos. 29 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Thomas G Brundige

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Alzina Brewer

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant):
(Address):

15. Filed Aug 15 1916 Jno. Verba Knox Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 8th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1916, to July 8th 1916, that I last saw h. im alive on July 7th 1916, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral apoplexy

(Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) Mitral insufficiency Arteriosclerosis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H W Wentworth M. D.
July 9 1916 (Address) Stites Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Stites
DATE OF BURIAL: July 9 1916

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 51

County of Canyon

Primary Registration District No. 2130

File No. 3 15276

City of Fruitland Ida. (No. ....., ... St.)

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Perdue Gladdish.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 18 (Day) 1869 (Year)

7. AGE: 47 yrs. ..... mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri.

10. NAME OF FATHER: Mr. O. V. Perdue.

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Sarah E. Whitthworth

13. BIRTHPLACE OF MOTHER (State or Country): Missouri.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed B. Gladdish

(Address) Payette Idaho

15.

Filed September 10 1916 Crispin Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1916, to Aug 12 1916, that I last saw her alive on Aug 1916, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 3 yrs. 0 mos. 9 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Drs Ponzuy & Reese M. D.

8/13 1916 (Address) Ontario, Ore.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: Aug 14th 1916

20. UNDERTAKER: D. K. Adair — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

Registration District No. 73

Primary Registration District No. 2110

(No. ....., ... St.)

File No. 15271

Registered No. 76

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esther Fullenwider

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. August 9 1916 (Month) (Day) (Year)

7. AGE: X Yrs. X Mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ralph Fullenwider

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Mila Stairs

13. BIRTHPLACE OF MOTHER (State or Country): Mrs.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ralph Fullenwider

(Address) Idaho Falls Ida

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 18 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17th 1916, to Aug 17th 1916, that I last saw h-r alive on Aug 17th 1916, and that death occured on the date stated above, at 3:30 A. M.

The CAUSE OF DEATH* was as follows:

Inanition

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. C. Hollister M. D.

9/7 1916 (Address) City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL

UNDERTAKER

Address

Filled in Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2117
(No. ..... St.)

File No. 15278
Registered No. 77

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucille Leisering

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
June (Month) 11 (Day) 1916 (Year)

7. AGE
Yrs. 0 Mo. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Wm. Leisering

11. BIRTHPLACE OF FATHER
(State or Country) Germany

12. MAIDEN NAME OF MOTHER Julia Foust

13. BIRTHPLACE OF MOTHER
(State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Julia Foust
(Address) Idaho Falls

15.
Filed 9/6 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 3 1916, to Sep 3 1916, that I last saw her alive on Sep 3 1916, and that death occured on the date stated above, at 1.4 M.

The CAUSE OF DEATH* was as follows:
Enteritis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S. S. Fuller M. D.
9/6 1916 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ross Hill
DATE OF BURIAL: Sept 4 1916

20. UNDERTAKER: G. H. Hunt
ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bannock

Primary Registration District No. 2 1 5 3

City of Ida Falls

(No. ....., ... St.)

File No. 15279

Registered No. 79

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wallace Leon Sappington

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Baby

6. DATE OF BIRTH: Aug (Month) 10 (Day) 1916 (Year)

7. AGE: 0 yrs. 0 mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho Falls Ida

10. NAME OF FATHER C. J. Sappington

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Mabel Heath

13. BIRTHPLACE OF MOTHER (State or Country) Ida Falls Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Phil J. Sappington
(Address) Idaho Falls Ida

15. Filed Sept 7 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1916 to Aug 11 1916, that I last saw him alive on Aug 11 1916 and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:
Failure of a certain valve to close at the time of birth.
(Duration) about One ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G W Pendleton M. D.
19 .... (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls Ida	Sept 8 1916

20. UNDERTAKER	ADDRESS
C E Dennwoodey	Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Dr Pendleton

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15280

Registered No. 71-

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2 1 V 3

2. FULL NAME Cornelia Bradbury

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH.: Aug (Month) 7 (Day) 1831 (Year)

7. AGE: 85 Yrs. ..... Mos. 9 ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): None

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: James Fulton

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm H Bradbury
(Address) Ucon Ida

15.
Filed Aug 17 1916 Guy Fernand
Local Registrar

SYMS - YORK CO., PTRS. & SOLS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Unknown
No medical attendance

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Guy Fernand M. D.

Aug 19 16 (Address) Ucon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rosehill — DATE OF BURIAL: Aug 17 1916

20. UNDERTAKER: G F Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15281
Registered No. 74

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bonneville
City of Ucon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13
Primary Registration District No. 2110
(No. ..... St.)

2. FULL NAME Fredericka Cramer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH. March 28 (Month) (Day) 1 (Year)
7. AGE: 69 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Denmark
10. NAME OF FATHER: Chasman Nelson
11. BIRTHPLACE OF FATHER (State or Country): " "
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alfred Cramer
(Address) Ucon Ida.
15. Filed Aug 16 1916 C. Fraud Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24652

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 14 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr 17 1916 to Aug 14 1916, that I last saw h[illegible] alive on Apr 17 1916 and that death occured on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis
(Duration) 4 Yrs. 1 mos. 16 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. Gillies M. D.
Aug 16. 1916 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ucon Idaho — DATE OF BURIAL: Aug 17 1916
20. UNDERTAKER: G. H. Hunt — ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2150
(No. ..... St.)

File No. 15282
Registered No. 96

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville
City of Idaho Falls

2. FULL NAME Ettie R. Platt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widow

6. DATE OF BIRTH. Dec 4 (Month) 4 (Day) 1867 (Year)

7. AGE 48 Yrs. 8 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Insurance Agent
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Chas. E. Lane

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Charlotte

13. BIRTHPLACE OF MOTHER (State or Country) Oshawa Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. G. Platt
(Address) Idaho Falls, Ida.

15. Filed Aug. 30 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1916, to Aug 28 1916, that I last saw her alive on Aug 28 1916, and that death occured on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:
Tuberculosis following acute suppurative appendicitis

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Acute appendicitis

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) C. G. Leonard M. D.

8/31 1916 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Idaho Falls — **DATE OF BURIAL** Aug 30 1916

20. UNDERTAKER G. H. Hunt. — **ADDRESS** Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO. PRTS. & BOOK. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2107
(No. ....., ... St.)

File No. 15283
Registered No. 2
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dim Hamilton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH ? (Month) (Day) 1 (Year)

7. AGE about 58 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Stock Ranch Hand
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) ?

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Deming & Clark
(Address) Dubois, Ida.

15.
Filed Sept 7 1916 Geo Fmunds
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug. (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1916 to Aug 10 1916
that I last saw ~~him~~ alive on Aug 10 1916
and that death occurred on the date stated above, at 9 M.
The CAUSE OF DEATH* was as follows:

Chronic Pneumonia Hypostatis

(Duration) 1 yrs. 6 mos. 10 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Cline M. D.
Aug 18 1916 (Address) Ida Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls, Ida	8/11 1916

20. UNDERTAKER	ADDRESS
E E Dunwoody	Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PRTS. & BDRS. 19760

Dr Cline

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2102
File No. 15284
Registered No. 21

1. PLACE OF DEATH.
County of Bannock
City of Idaho Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fay Empey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH.
June (Month) 11 (Day) 1908 (Year)

7. AGE
8 Yrs. 2 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Adrian Empey

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Flossie Williams

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Adrian Empey
(Address) R D 2 Ida Falls

15.
Filed Aug 17 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 5 P M.
The CAUSE OF DEATH* was as follows:

Lightning Shock
27 miles East Idaho Falls

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C C Dunwoody Coroner M. D.
19..... (Address) Ida Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ammon, Ida
DATE OF BURIAL: 8/17 1916

20. UNDERTAKER: C C Dunwoody
ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15285
Registered No. 50

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2102
(No. ....., ... St.)

2. FULL NAME Alma Grant Lindholm

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 10 (Day) 1900 (Year)

7. AGE: 15 yrs. 10 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Alma E Lindholm

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Agnes Smith

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alma E Lindholm by Tel. Phone
(Address) Iona, Ida

15. Filed Sept 1 1916 A Smart Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Drowning. While bathing

(Duration) ½ yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Dinwoody M.D.

19.... (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida
DATE OF BURIAL: 8/6 1916

20. UNDERTAKER: C E Dinwoody
ADDRESS: Idaho Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15287

Registered No. 128

1. PLACE OF DEATH.

County of Cassia

City of Burley

(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 117

Primary Registration District No. 2196

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby W. H. Thorne.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug. (Month) 4 (Day) 1916 (Year)

7. AGE: ....Yrs. ....Mos. 2 hours ds.

IF LESS than 1 day how many .....hrs. or 2 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Burley Ida Cassia Co.

10. NAME OF FATHER William Heber Thorne.

11. BIRTHPLACE OF FATHER (State or Country) England.

12. MAIDEN NAME OF MOTHER Bertha A. Bucketed.

13. BIRTHPLACE OF MOTHER (State or Country) Salt Lake City Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Thorne

(Address) Burley Idaho

15. Filed Aug. 5th 1916. D. J. Patterson Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1916, to Aug 4 1916, that I last saw her alive on Aug 4 1916, and that death occured on the date stated above, at 17:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) G. F. Smith M. D.

8/5 1916 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: Aug 6 1916

20. UNDERTAKER: L. Gallogly — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 6196
File No. 12489
Registered No. 15289

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ira Minter Robinson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
June (Month) 27 (Day) 1916 (Year)

7. AGE
~~21~~ Yrs. 1 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Burley Ida.

10. NAME OF FATHER: John S. Robinson

11. BIRTHPLACE OF FATHER
(State or Country) Indiana

12. MAIDEN NAME OF MOTHER: Violetta Allen

13. BIRTHPLACE OF MOTHER
(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. S. Robinson
(Address) Burley Idaho

15.
Filed Aug. 23rd 1916. Dr. J. C. Patterson Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
8 (Month) — 22 (Day) — 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27-1916, to Aug. 22nd 1916, that I last saw h.im alive on Aug. 21- 1916, and that death occured on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:
Stenosis Pylorus

..... (Duration) — Yrs. Few months ds.

Contributory (Secondary)
— (Duration — Yrs. — mos. — ds.

(Signed) G. H. Cooper M. D.
19.... (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: Aug. 23 1916

20. UNDERTAKER: L. B. Gallagly — ADDRESS: Burley Ida.

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 15290
Registered No. 129

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Lewis Zingel.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug. (Month) 18 (Day) 1861 (Year)

7. AGE: 54 Yrs. 11 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer stoker.

9. BIRTHPLACE (State or Country): Dubuque Iowa.

10. NAME OF FATHER: August Zingel.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs R. L. Howe
(Address) 263-13th St. W. Eugene Oregon

15. Filed Aug. 9th 1916. Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 9th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20th 1916, to Aug. 9th 1916, that I last saw him alive on July 8th 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Gastric Ulcer
(Duration) Several Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
8-9 1916 (Address) Burley, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: Aug. 12 1916

20. UNDERTAKER: L. B. Gallogly — ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRD - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15291

Registered No. 127

1. PLACE OF DEATH.

County of Cassia

City of Burley

(No. ....., ... St.)

Registration District No. 127

Primary Registration District No. 3107

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reeta May McBride

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 2 (Day) 1912 (Year)

7. AGE: 4 Yrs. 4 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oakley Ida

10. NAME OF FATHER: J D McBride

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sadie Whittle

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J D McBride

(Address) Burley Ida

15. Filed Aug 6th 1916. D. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 5. (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5. 1916. to aug 5. 1916., that I last saw h~~e alive on~~ Aug. 5. 1916. and that death occured on the date stated above, at ——— M.

The CAUSE OF DEATH* was as follows: Suffocation due to fall in supply pool of water, the child was dead when I first saw her.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm Schultz M. D.

8/7 1916 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Ida — DATE OF BURIAL: Aug 6 1916

20. UNDERTAKER: Lucas — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SONS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 15292
Registered No. 126

1. PLACE OF DEATH.
County of Cassia
City of Burley.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucy Ann Kidd.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 6 (Day) 1840. (Year)

7. AGE: 76 Yrs. 8 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Georgia

10. NAME OF FATHER Joel Maultrie

11. BIRTHPLACE OF FATHER (State or Country) Georgia

12. MAIDEN NAME OF MOTHER Elisebeth Carr

13. BIRTHPLACE OF MOTHER (State or Country) So. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Peter Kidd
(Address) Burley Ida

15.
Filed Aug. 15th 1916. Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 15th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1916, to Aug. 15th 1916, that I last saw h.e.r. alive on Aug. 15th 1916, and that death occured on the date stated above, at 9 a M.

The CAUSE OF DEATH* was as follows:
Cancer of Breast.

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
8-15 1916 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Idaho. DATE OF BURIAL: Aug. 16 1916.

20. UNDERTAKER: J. Gallogly. ADDRESS: Burley Ida.

BYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2075
File No. 15293
Registered No. 22

1. PLACE OF DEATH.
County of Blaine
City of Carey
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 8 (Day) 1869 (Year)

7. AGE: 46 Yrs. 8 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Joseph Shippen

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Jane Hudson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Emma Shippen
(Address) Carey Idaho

15. Filed Aug. 11 1916 Robt H. Wright Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1916, to July 16 1916, that I last saw him alive on July 15 1916, and that death occured on the date stated above, at 5 A M.
The CAUSE OF DEATH* was as follows:
Struck by lightning
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. J. Paar M. D.
19 ..... (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Carey Ida — DATE OF BURIAL: July 18 1916

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7 8 M C
Primary Registration District No. 2183
(No. .... St.)

File No. 15294
Registered No. 907

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Velva Gregory

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Sept. (Month) 27 (Day) 1898 (Year)

7. AGE: 17 Yrs. 9 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: Norris A. Overmyer

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Nina C. Chesbro

13. BIRTHPLACE OF MOTHER (State or Country): Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) N. A. Overmyer
(Address) Sandpoint Idaho

15.
Filed July 11 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1916, to July 10 1916, that I last saw her alive on July 10 1916, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Acute Gastritis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.
Aug 10 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos. 3 days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? Elmira Idaho.
Former or usual residence Elmira Idaho.

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho — DATE OF BURIAL: 7/12 1916

20. UNDERTAKER: E M Brown — ADDRESS: S P.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
(No. ..... St.)
File No. 15296
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of St Anthony
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth McArthur
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Nov (Month) 12 (Day) 1849 (Year)

7. AGE 66 Yrs. 9 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Jacob Abbott

11. BIRTHPLACE OF FATHER (State or Country): Ia

12. MAIDEN NAME OF MOTHER: Elizabeth J Bickmore

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Steve McArthur
(Address) St Anthony

15. Filed Aug 26 1916
W D Wood
Local Registrar

SYMS - YORK CO., PYRS. & SONS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 1916, to Aug 24 1916, that I last saw her alive on Aug 23 1916, and that death occured on the date stated above, at 4 9 M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Cerebritis
(Duration 2 yrs. ..... mos. ..... ds.
(Signed) A Moorhead M. D.
8/25 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Milford Cemetery
DATE OF BURIAL: 8/25 1916

20. UNDERTAKER: Phillips
ADDRESS: Rexburg

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 15297
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of St Anthony
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vesta Winkler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Apr (Month) 6 (Day) 1885 (Year)

7. AGE: 31 Yrs. 4 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: C. M. Winkler

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Nettie Rusler

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nettie Winkler
(Address) St Anthony Idaho

15. Filed Aug 30 1916
W. B. Wirt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1916, to Aug 22 1916, that I last saw h alive on Aug 22 1916, and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Typhoid

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Asthma

(Duration 29 yrs. ..... mos. ..... ds.

(Signed) A Moorehead M. D.

8/26 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Anthony — DATE OF BURIAL: 8/26 1916

20. UNDERTAKER: W D Gregg — ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15298

Registered No. .....

Registration District No. 99

Primary Registration District No. 2177

1. PLACE OF DEATH.

County of Fremont

City of PSt. Anthony

(No. Parker Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph S. Miller

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widdowed

6. DATE OF BIRTH. August (Month) 12 (Day) 1847 (Year)

7. AGE: 68 Yrs. 11 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Daniel A. Miller

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Hannah Biglow

13. BIRTHPLACE OF MOTHER (State or Country): Verg.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Miller

(Address) Parker Idaho

15. Filed Sept 10 1916 W. D. Yager Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/7 1916, to 8/8 1916, that I last saw h[illegible] alive on 8/7 1916, and that death occured on the date stated above, at 7.15 A M.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(Duration) 5 Yrs. mos. ds.

Contributory (Secondary) senility

(Duration yrs. mos. ds.

(Signed) F. E. Boucher M. D.

Aug 8 1916 (Address) St. Anthony, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Farmington Utah

DATE OF BURIAL: Aug 9 1916

20. UNDERTAKER: W. D. Yager

ADDRESS: St Anthony, I

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 15299
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of St Anthony
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grant L. Alvaglen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, ~~MARRIED~~, WIDOWED OR DIVORCED. (Write the word.): Boy

6. DATE OF BIRTH. Oct. (Month) 4 (Day) 1914 (Year)

7. AGE: 1 Yrs. 11 Mos. — ds. —
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wilford. Idaho

10. NAME OF FATHER: Conrad. Alvaglen

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Magdelen - Minie

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Conrad Alvaglen
(Address) St. Anthony R F D 1

15. Filed Sept 15 1916 W. D. Weeks Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28 1916, to Sept 4 1916, that I last saw h alive on Sept 4 1916, and that death occured on the date stated above, at 3P M.

The CAUSE OF DEATH* was as follows:
Acute Dysentery

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. Morstead M. D.
9/15 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days In the State .....yrs .....mos .....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilford — DATE OF BURIAL: 9/16 1916

20. UNDERTAKER: J Rigsmy ADDRESS: Ashley

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2776
(No. ..... St.)

File No. 15300
Registered No. 129
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ebe Fillmore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Mar (Month) 31 (Day) 1916 (Year)

7. AGE: 0 yrs. 3 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ray Fillmore

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Margaret Jones

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray L Fillmore
(Address) Rigby Idaho

15. Filed Sept 10 1916 Ray H Fiske. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1916, to July 27 1916, that I last saw her alive on July 27 1916, and that death occurred on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:
Acute Gastro-Enteric intoxication

(Duration) 0 yrs. 0 mos. 9 ds.
Contributory (Secondary) Acute Myocarditis
(Duration) 0 yrs. 0 mos. 4 ds.

(Signed) A. M. Palmer M. D.
July 27 1916 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 0 yrs. 3 mos. 28 days. In the State 0 yrs. 3 mos. 28 days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby Idaho
DATE OF BURIAL: 7/29 1916

20. UNDERTAKER: Hoots Friends
ADDRESS: Rigby, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98

County of Jefferson

Primary Registration District No. 276

City of Rigby

(No. ..... , ... St.)

File No. 15301

Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Brock Jenkins

If death occured in a hospital, institution or camp, give its NAME instead of street and number,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~ Married

6. DATE OF BIRTH: June (Month) 16 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Daniel Jenkins

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Florence Beard

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daniel Jenkins

(Address) Rigby Idaho

15. Filed Sept 10 1916 Ray W. Parker. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1916, to July 11 1916, that I last saw him alive on July 11 1916, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Acute gastro enteritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Pulmonary Oedema

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. L. Call M. D.

19.... (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 27 days. In the State 0 yrs. 0 mos. 27 days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grant Idaho

DATE OF BURIAL: July 13 191[illegible]

20. UNDERTAKER: Knox Friends

ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 15302
Registered No. 27

1. PLACE OF DEATH.
County of Jefferson
City of Lewisville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs M Ball

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: May (Month) 10 (Day) 1837 (Year)

7. AGE: 84 yrs. 3 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Richard Ball

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hanna Mitchell

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alfred Ball
(Address) Lewisville Idaho

15. Filed Sept 10 1916 Ray Fiske. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1916, to Aug 23 1916, that I last saw him alive on Aug 18 1916, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Old Age & Senility

(Duration) ..... yrs. 3 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A A Anderson M. D.

Aug 23 1916 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby Ida — DATE OF BURIAL: 8/26 1916

20. UNDERTAKER: F E Dunwoody — ADDRESS: Ida Falls Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 15303
Registered No. 176

1. PLACE OF DEATH.
County of Jefferson
City of Ryley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Evangeline Newman
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept 11 (Month) (Day) 1914 (Year)

7. AGE: 1 yrs. 10 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ryley Idaho

10. NAME OF FATHER: Thos M Newman

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Bertha Mech

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. W. Newman.
(Address) Ryley Idaho.

15. Filed Sept 10 1916 Ray H. Fick. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st 1916, to Aug 7 1916, that I last saw her alive on July 10 1916, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Copedlow Bronchitis

(Duration) 0 yrs. 0 mos. 10 ds.

Contributory Intestinal Catarrah.
(Secondary)

(Duration) 1 yrs. mos. ds.

(Signed) H. A. Anderson M. D.
Aug 9 1916 (Address) Ryley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ryley Idaho
DATE OF BURIAL: Aug 9 1916

20. UNDERTAKER: Home Friends
ADDRESS: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15304
Registered No. 27

1. PLACE OF DEATH.
County of Jefferson
City of Ora Rigby
(No. ....., ... St.)
Registration District No. 98
Primary Registration District No. 2116
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Lisle Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH
July (Month) 9 (Day) 1915 (Year)

7. AGE
1 yrs. 1 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER James Jones

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Hazel Bennet

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. E. Ford
(Address) Rigby Idaho

15. Filed Sept 10 1916 Ray H. Tinker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1916, to Aug 2 1916, that I last saw him alive on Aug 2 1916, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Drowning

Disinterred Lidia alive

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. C. Gaston M. D.
8/3 1916 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Ogden Utah | DATE OF BURIAL Sept 1916

20. UNDERTAKER G. A. Hunt | ADDRESS Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15305
Registered No. 28

1. PLACE OF DEATH.
County of Jefferson
City of Rigby Idaho (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176

2. FULL NAME Robt Corbett McNeil

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	Married

6. DATE OF BIRTH: July (Month) 8 (Day) 1860 (Year)

7. AGE: 56 yrs. 1 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John McNeil

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Mary J. Quinn

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robt McNeil
(Address) Rigby

15. Filed Sept 10 1916 Ray V. Tibbs. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1916, to May 31 1916, that I last saw him alive on July 7 1916, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis and
pneumonia
(Duration) ..... yrs. 1/2 mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. A. Anderson M. D.
July 31 1916 (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelton Idaho | DATE OF BURIAL: Aug 1916

20. UNDERTAKER: Friends | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Jefferson

City of Rigby

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98

Primary Registration District No. 2176

(No. ....., ... St.)

File No. 15306

Registered No. 20

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph A Ledrina

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH: Apr. (Month) 23 (Day) 1846 (Year)

7. AGE: 70 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. T. Ledrina
(Address) Roberts Idaho

15. Filed Sept 10 1916 Ray H. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9 1916, to Sept 14 1916 that I last saw him alive on Sept 14 1916 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute pericarditis

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) Bright's Disease

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. B. Beller M. D.

9/14 1916 (Address) Roberts Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Roberts — DATE OF BURIAL: Sept 16 1916

20. UNDERTAKER: Gilstrap — ADDRESS: Idaho Falls

CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S: No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 70

Primary Registration District No. 101

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15309

Registered No. 59

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. Corner Cedar & Wasatch St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bernice Belsey Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: Yrs. 2 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wallace Idaho

10. NAME OF FATHER: Wm G Clark

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Minnie Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William G. Clark

(Address) Wallace Ida

15. Filed July 5 1916 F Leo Turnipseed Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 4th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1916, to July 4 1916, that I last saw her alive on July 4 1916, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D Mowry M. D.

July 6 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Damascus Maine

19. PLACE OF BURIAL OR REMOVAL: Wallace

DATE OF BURIAL: July 6 1916

20. UNDERTAKER: Ward Hud Co

ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15310

Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. Wallace Hospital St.)

Registration District No. 70

Primary Registration District No. 101

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Ezkiel

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. .....(Month) .....(Day) 1.....(Year)

7. AGE: 51 Yrs. — Mos. — ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Miner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER not given

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ca. Dept. Mines

(Address) Burke, Ida

15. Filed Aug 10 1916 F Leo Temple Local Registrar

SVMS - YORK CO., PTRS. U. SOES. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1916, to Aug 9 1916, that I last saw h.. alive on Aug 9 1916 and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

.....(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) Chronic Nephritis

.....(Duration — yrs. ..... mos. ..... ds.

(Signed) Chas. G. Dettman M. D.

Aug 10 1916 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: Aug 12 1916

20. UNDERTAKER: W B Worstell — ADDRESS: Wallace

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15311

Registered No. 47

1. PLACE OF DEATH.

Registration District No. 10

Primary Registration District No. 1011

County of Shoshone

City of ..... (No. Coeur d'Alene Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mike Stillon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 23 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Stillon

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B.G. Worstell

(Address) Wallace Ida

15. Filed Aug 16 1916 F Leo Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Crushed by falling ground.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Chas. R. Mower M.D.

Aug 16 1916 (Address) Wallace Ida

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: Aug 16 1916

20. UNDERTAKER: B.G. Worstell — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15312

Registered No. 73

Registration District No. 70

Primary Registration District No. 101

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. or Street of Wallace (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1 (Year)

7. AGE 44 Yrs. 6 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Miner
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. N. Bain
(Address) .....

15.
Filed Aug 22 1916 F Leo Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17 1916, to Aug 17 1916, that I last saw h[illegible] alive on 16 Aug. M. 1916, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Suicide
Carbolic acid
(Duration) — Yrs. — mos. — ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. E. Dettman M. D.
1916 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Idaho	Aug 22 1916

20. UNDERTAKER	ADDRESS
B G Moretti.	Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15313

Registered No. 67

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1014

(No.) Wallace Hospital

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Despard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: 50 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: teamster

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A Sutherland

(Address) Wallace Ida

15. Filed July 21 1916 F Leo Zumpfy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 20 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1916, to July 20 1916, that I last saw h— alive on July 19 1916, and that death occured on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Rectal fistula

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. A. Sutherland M. D.

19 ..... (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. — mos. — days. In the City of Wallace State 3 yrs. — mos. — days

Where was disease contracted if not at place of death? Wallace Ida.

Former or usual residence Wallace Ida

19. PLACE OF BURIAL OR REMOVAL: Grace Cemetery — DATE OF BURIAL: July 24 1916

20. UNDERTAKER: Wallace Ida — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD-YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 1011
File No. 15314
Registered No. 68

1. PLACE OF DEATH.
County of Shoshone
City of Wallace (No. Home St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Walter Burns

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH. Unknown
(Month) (Day) 1 (Year)

7. AGE 56 Yrs. Mos. ds.
IF LESS than 1 day how many ...hrs. or ...min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emil P Pfister
(Address) Wallace

15. Filed July 23 1916 F Leo Dunphy Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1916, to July 19 1916, that I last saw him alive on July 19 1916, and that death occured on the date stated above at 7A M.

The CAUSE OF DEATH* was as follows: Carcinoma Liver

(Duration) / Yrs. mos. ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.

(Signed) D P Moriarty M. D.
July 22 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs ...mos ...days. In the State ...yrs ...mos ...days
Where was disease contracted if not at place of death?
Former or usual residence Wallace Ida

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Ida	July 25 1916

20. UNDERTAKER	ADDRESS
Ward Und Co	Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15315

Registered No. 64

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 7

Primary Registration District No. 10 (No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME [redacted] Lillian Laurtzen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 21 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Dan Rhine

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis M Laurtzen

(Address) Wallace Idaho

15. Filed July 25 1916 F Leo Jumper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 24th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jul 10 1916, to Jul 24 1916, that I last saw h[illegible] alive on Jul 23 1916 and that death occured on the date stated above, at 4.40 P.M.

The CAUSE OF DEATH* was as follows:

Pyaemia Abscess
followed by general
Peritonitis

(Duration) Yrs. mos. ds.

Contributory (Secondary) Tuberculosis Pulmonalis

(Duration) 2 yrs. mos. ds.

(Signed) Dr S Mowry M.D.

7/24 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence: Wallace Ida

19. PLACE OF BURIAL OR REMOVAL: Tekoa Wash — DATE OF BURIAL: July 25 1916

20. UNDERTAKER: Ward Undt Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15316

Registered No. 65

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 10

Primary Registration District No. 1011

(No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J. Mackey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 63 Yrs. — Mos. — ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): //

12. MAIDEN NAME OF MOTHER: //

13. BIRTHPLACE OF MOTHER (State or Country): //

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. Leo Sunday

(Address) Wallace

15. Filed July 20 1916 F Leo Sunday Local Registrar

SYRACUSE YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... (Month) ..... (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1914, to July 16 1916, that I last saw h— alive on July 16 1916, and that death occured on the date stated above, at 5— M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cardiac asthma

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Williams M. D.

19..... (Address) Burke Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: July 20 1916

20. UNDERTAKER: D. Mattes — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15317

Registered No. 52

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 20
Primary Registration District No. 1014
(No. Providence Hosp. St.)

2. FULL NAME Clarence F. Dahlquist

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 25 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Musician
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rhode Island

10. NAME OF FATHER: Frank Dahlquist

11. BIRTHPLACE OF FATHER (State or Country): not given

12. MAIDEN NAME OF MOTHER: Hilda ~~~

13. BIRTHPLACE OF MOTHER (State or Country): not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank A. Venable
(Address) Wallace, Idaho

15.
Filed July 3rd 1916
H Leo Sunder
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1916, to July 1 1916
that I last saw h~~e~~r alive on July 1 1916
and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows: Penetrating gun shot wound right lung

..... (Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D^r Mowry M. D.
July 3 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Omaha Neb
DATE OF BURIAL: July 3 1916

20. UNDERTAKER: K & K Mortuary
ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15318
Registered No. 37

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of [redacted] (No. Atlanta Ida St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Sebert N. Smith
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Sept (Month) 9 (Day) 1885 (Year)
7. AGE: 30 yrs. 10 mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Teamster
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Missouri
10. NAME OF FATHER: W. L. Smith
11. BIRTHPLACE OF FATHER (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Annie M. Hobbs
13. BIRTHPLACE OF MOTHER (State or Country): Missouri
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. Hobbs
(Address) 112 Hwy St.
15. Filed July 7 1916 F. Leo Sunday Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jul (Month) 1 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw him alive on Jul 1 1916
and that death occurred on the date stated above, at 7:00 M.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
Stroke of Lightning
(Duration) ..... yrs. 1 mos. 1 ds.
Contributory (Secondary) None
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Dr. Mountz M. D.
7/3 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sprague Wash
DATE OF BURIAL: July 4 1916
20. UNDERTAKER: D. G. Worstell
ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 20

Primary Registration District No. 104

(No. Wallace Hospital)

File No. 15319

Registered No. 58

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria Lenora McLeod

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fema[le]

4. COLOR OR RACE: Cahuli

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 3 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: John McLeod.

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Cassie McLeod

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine McLeod

(Address) Mullan Idaho

15. Filed July 3 1916 F Leo Trump Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 2 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1916, to July 2nd 1916, that I last saw h[er] alive on July 2nd 1916, and that death occured on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) Yrs. mos. 2 wks ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) [illegible] M. D.

7-3-16 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Mullan Idaho.

19. PLACE OF BURIAL OR REMOVAL: Mullan Ida

DATE OF BURIAL: 7/4 1916.

20. UNDERTAKER: Ward Mud Co

ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15320

Registered No. 60

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 76

Primary Registration District No. 1091

(No. One St. near Second St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Guy Clifford Darst

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Nov (Month) 30th (Day) 1891 (Year)

7. AGE 24 Yrs. 7 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Electrician

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Horatio Harry Darst

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Kay

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H H Darst

(Address) Marshfield Ore

15. Filed July 7 1916 F Leo Turnbull Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw him alive on ..... 191..., and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows: Accidentally electrocuted by coming in contact with live wire

(Duration) ..... Yrs. Instant ds.

Contributory (Secondary) None

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D S Moriarty M. D.

July 8 1916 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: July 8 1916

20. UNDERTAKER: J G Worstell ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15321

Registered No. 62

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. Providence Hosp. St.)

Registration District No. 20

Primary Registration District No. 10 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Martin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) (Year)

7. AGE: 34 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: A. Doucette

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Not given

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. Martin

(Address) Gem Idaho

15. Filed July 8 1916 T. Leo Finnley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 8 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1916, to July 8 1916, that I last saw h[illegible] alive on July 8 1916, and that death occured on the date stated above, at 3½ A.M.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(Duration) Yrs. 1 mos. — ds.

Contributory (Secondary): Nephritis

(Duration) Yrs. mos. ds.

(Signed) D. G. Mowry M. D.

(Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the city of Wallace State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? Gem Idaho

Former or usual residence: Gem Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: July 10 1916

20. UNDERTAKER: B. G. Worstell — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

RECEIVED APR 1 - 1935

15321

N. B.---WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

PLACE OF DEATH

County of Shoshone

City of Wallace

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.

Registration District No. 70

Primary Registration District No. 1011 Local Registrar's No. 62

(No. Providence Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Catherine Martin.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and state)

Length of residence in city or town where death occurred, yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed or Divorced, (write the word)
F.	W.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
34			

OCCUPATION

8. Trade, profession, or particular kind of work done, as **spinner, sawyer, bookkeeper, etc.** Housewife.

9. Industry or business in which work was done, as **silk mill, saw mill, bank, etc.**

10. Date deceased last worked at this occupation (mo. and yr.)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Canada.

MOTHER OF FATHER

13. NAME A Doucette

14. BIRTHPLACE (city or town) (State or country) Canada

15. MAIDEN NAME Not Given.

16. BIRTHPLACE (city or town) (State or country) " "

17. INFORMANT (Address) J.A. Martin Gem Ida.

18. BURIAL, CREMATION OR REMOVAL
Place. Wallace Ida. Date July 10, 1916

19. UNDERTAKER (Address) P.L. Worstell

20. FILED July 8, 1916. P.L. Quigley. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day and year) July 8 1916

22. I HEREBY CERTIFY, That I attended deceased from July 7, 1916, to July 8, 1916.

I last saw her alive on July 8 1916.; death is said to have occurred on the date stated above, at 3:3A. m.

The **principal cause of death** and related causes of importance were as follows:

	Date of onset
Puerperal eclampsia	
Other **contributory causes** of importance:	
Nephritis	

Name of operation ..... Date of .....

What test confirmed diagnosis? .... Was there an autopsy? ..

23. If death was due to exter'l causes **(violence)** fill in also the following:
Accident, suicide, or homicide? ..... Date of injury .., 193.

Where did injury occur? .....
(Specify city or town, county, and state)

Specify whether injury occurred in **industry**, in **home**, or in **public place.** .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased, if so, state how? .....

(Signed) Drs. Mowery & Mowery, M. D.

(Address) Wallace Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 1011
(No. Providence Hospital)
File No. 15322
Registered No. 63

1. PLACE OF DEATH
County of Shoshone
City of Wallace

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Kuusti

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 18 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Boone Montana

10. NAME OF FATHER: Mat Lopi

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Anna Maria Lopi

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Kuisti
(Address) Enaville Idaho

15. Filed July 14 1916 F. Leo Dunphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1916, to July 12 1916, that I last saw h[illegible] alive on July 12 1916, and that death occured on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Cerebro spinal meningitis
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) .....
(Duration) ..... mos. ..... ds.

(Signed) D. P. Mowry M. D.
July 13 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Enaville Idaho

19. PLACE OF BURIAL OR REMOVAL: Enaville Ida — DATE OF BURIAL: July 14 1916

20. UNDERTAKER: Ward Hud Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

County of Shoshone | Registration District No. ..... | Bureau of Vital Statistics

City of Wallace | Primary Registration District No. 121 | File No. 15324

(No. Anderson Siding on North Fork) | Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Abner G Kerns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

The information on this certificate is an exact COPY of the official certificate filed at place of death.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed or Divorced. (Write the Word)
Male	White	Married

6. DATE OF BIRTH.

.....191...
(Month) (Day) (Year)

7. AGE

42 Yrs ... Mos ... ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.. Attorney at law

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Pennsylvania

10. NAME OF FATHER Not given

11. BIRTHPLACE OF FATHER

(State or Country) "

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A Sutherland C...

(Address) Wallace Ida.

15. Filed Aug 11 191 6 F. Lee Jones
Local Registrar.

Place Where Remains are to be Sent. Wallace Ida | Date of Shipment 8/10...1916

SHIPPING UNDERTAKER B G Worstell

ADDRESS Wallace ..... Firm Name.. Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH.

Aug 10th 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....191..., to .....191...,

that I last saw h.....alive on .....191....,

and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH was as follows:

...Drowning in North Fork

...Coeur d'Alene River

.....

.....(Duration) .....Years .....mos.. ..ds.

Contributory (Secondary) .....

.....(Duration) .....Years.....mos....ds.

(Signed) Chas. D. Mowry M. D.

8/10....1916 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)

At place of death....yrs....mos....days | In the State ....yrs...mos...days

Where was disease contracted if not at place of death .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Wallace Ida | Date of Burial Aug 10. 1916.

20. UNDERTAKER B G Worstell | Address Wallace Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15326

Registered No. 42

1. PLACE OF DEATH.

County of Clearwater

City of Orofino, Ida

(No. ....., ... St.)

Registration District No. 90

Primary Registration District No. 765

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Hales

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) — (Day) — 1849 (Year)

7. AGE: 67 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Lumber Jack

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A Blanton

(Address) Orofino Ida

15. Filed Sept 1 1916 J. McKirby Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1916, to August 31" 1916, that I last saw him alive on August 31" 1916 and that death occured on the date stated above, at 3.20 P.M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(Duration) 9 Yrs. mos. ds.

Contributory (Secondary) Insanity

(Duration) yrs. 6 mos. ds.

(Signed) John Stevens M. D.

Aug 31 1916 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. 4 mos. 21 days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence N. I. Sanitarium

19. PLACE OF BURIAL OR REMOVAL: Sanitarium Cemetery

DATE OF BURIAL: Sep 2 1916

20. UNDERTAKER: P. M. Johnson

ADDRESS: Orofino, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 15327
Registered No. 6

1. PLACE OF DEATH.
County of Clearwater
City of Orofino.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME B. F. Kerr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. (Month) ..... (Day) ..... 1858 (Year)

7. AGE: 58 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... merchant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Stevens
(Address) Orofino, Idaho.

15. Filed July 10 1916 — J. M. Davis, Local Registrar

SYMS-YORK CO., PTPS. & BKBS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1914, to July 5 1916, that I last saw h[illegible] alive on July 4 1916, and that death occured on the date stated above, at 9.47 A. M.

The CAUSE OF DEATH* was as follows:
General Paresis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory — (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John Stevens M. D.
July 5 1916 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 9 mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Boise Idaho
Former or usual residence Idaho.

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida — DATE OF BURIAL: 7/7 1916

20. UNDERTAKER: F. A. Shaw — ADDRESS: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15328

Registered No. .....

Registration District No. 1 24

Primary Registration District No. .....

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Ada

City of Kuna R.F.D

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Ester Grisham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 24 1916 (Month) (Day) (Year)

7. AGE: Yrs. 4 Mos. 2 ds. X

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... ✓

9. BIRTHPLACE (State or Country) Kuna Idaho

10. NAME OF FATHER H. V. Grisham

11. BIRTHPLACE OF FATHER (State or Country) Everton, Mo

12. MAIDEN NAME OF MOTHER Cora Jerome

13. BIRTHPLACE OF MOTHER (State or Country) Everton Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. V. Grisham

(Address) Kuna Idaho

15. Filed July 26 1916 F. L. McCauley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 26th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1916, to June 10 1916, that I last saw her alive on June 10 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows: Chronic Indigestion

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. 2 mos. 2 ds.

(Signed) F. L. McCauley M. D.

7/26 1916 (Address) Kuna, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kuna Cemetary — DATE OF BURIAL: 7/29 1916

20. UNDERTAKER: Had none — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

Dr. Lindsay.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15329

Registered No.

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 1201

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrea Rinaldi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	Single

6. DATE OF BIRTH: Nov. (Month) 18 (Day) 1914 (Year)

7. AGE: 1 yrs. 8 mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kellogg, Idaho.

10. NAME OF FATHER John Rinaldi

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER Esther Negobbi

13. BIRTHPLACE OF MOTHER (State or Country) Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Rinaldi
(Address) Kellogg, Idaho

15. Filed 8/1/16 1916 Geo S Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1916, to July 2nd 1916, that I last saw him alive on July 1st 1916, and that death occurred on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia

(Duration) yrs. mos. 15 ds.
Contributory Chicken Pox
(Secondary)
(Duration) yrs. mos. ds.

(Signed) M. C. Lindsay M. D.
7/31 1916 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho | DATE OF BURIAL: July 3 1916

20. UNDERTAKER: M. C. Thornhill | ADDRESS: Kellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 723
Primary Registration District No. 7201

File No. 20 15330
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gail George Vanderen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Married

6. DATE OF BIRTH: Feb (Month) 22 (Day) 1892 (Year)

7. AGE: 24 yrs. 4 mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Millman
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Adolphus Jackson Vanderen

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Glenora Emily

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Glenora Babbitt
(Address) Kellogg, Idaho

15. Filed 8/16 1916 Geo. D. Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidentally drowned in North Fork Coeur d'Alene River

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho | DATE OF BURIAL: July 21 1916

20. UNDERTAKER: M. C. Thornhill ADDRESS Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Cataldo
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 127
Primary Registration District No. 2201
(No. ....., ... St.)

File No. 15331
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Duncan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	White	Married

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
80 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Invalid
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) California

10. NAME OF FATHER
no info.

11. BIRTHPLACE OF FATHER
(State or Country) no info.

12. MAIDEN NAME OF MOTHER
no info

13. BIRTHPLACE OF MOTHER
(State or Country) no info.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. W. Hyatt
(Address) Cataldo, Idaho

15.
Filed 7/7/16 1916 Geo S Lesher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on July 4 1916,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis
.....
.....
..... (Duration) ..... yrs. ..... mos. 3 ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) M C Lindsay M. D.
7/31 1916 (Address) Kellogg Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cataldo Cemetery Cataldo Idaho	July 5 1916
20. UNDERTAKER	**ADDRESS**
M. C. Thornline	Kellogg Ida

SYMS - YORK CO., PTRS. & SDRS. 19760

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 15333
Registered No. .....

1. PLACE OF DEATH.

County of .....
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Harriet Kinney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH.
October (Month) Sixth (Day) 1844 (Year)

7. AGE
71 Yrs. 9 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Missouri

10. NAME OF FATHER
Land

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER
Elizabeth Hill Gaul

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. W. Kinyon
(Address) .....

15.
Filed 8-2 1916
J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1916, to Aug 1 1916,
that I last saw her alive on July 31 1916,
and that death occured on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Murphy M. D.
8-2 1916 (Address) Buhl Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Clinton Mo
DATE OF BURIAL: .....191.....

20. UNDERTAKER: C. J. Crosby
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15334
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl Ida (No. ....., ... St.)

Registration District No. 34
Primary Registration District No. 2687

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna F. Twidy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Dec. (Month) 6 (Day) 1875 (Year) ~~1878~~
7. AGE: 41 yrs. 7 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: farmers wife
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Bohemia
10. NAME OF FATHER: John Naviatil
11. BIRTHPLACE OF FATHER (State or Country): Bohemia
12. MAIDEN NAME OF MOTHER: Anna Naviatil
13. BIRTHPLACE OF MOTHER (State or Country): Bohemia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Twidy
(Address) .....
15.
Filed 8-13 1916. J. A. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. (Month) 11 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occurred on the date stated above, at P.M.
The CAUSE OF DEATH* was as follows:
Sudden death, probably disease of heart.
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. Wellhouse M. D.
Aug 12 1916 (Address) Buhl

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls. Ida
DATE OF BURIAL: 8/14 1916

20. UNDERTAKER: J. E. Schmidt
ADDRESS: Buhl. Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Burbl
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 39
Primary Registration District No. 2087
(No. ....., ... St.)

File No. 15335
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME. Ina Alleson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	single

6. DATE OF BIRTH: Jan (Month) 7 (Day) 1902 (Year)

7. AGE: 14 yrs. 7 mos. 21 ds. — IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Copenhagen Denmark

10. NAME OF FATHER: Niels P Alleson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Johanna Olson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Niels P Alleson
(Address) Burbl Ida

15. Filed 8-29 1916. J. Mccoffley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1916, to Aug 28 1916
that I last saw h alive on Aug 26 1916
and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever.
.....
.....
(Duration) ..... yrs. ..... mos. 25 ds.

Contributory (Secondary) None
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Thackray M. D.
8/28 1916 (Address) Burbl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Burbl Ida — DATE OF BURIAL: 8/29 1916

20. UNDERTAKER: J E Schmidt — ADDRESS: Burbl

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No. 29

Primary Registration District No. 1050

(No. ....., ... St.)

File No. 7

Registered No. 15336

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant child of F. H. Urmson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept. 6 1916 (Month) (Day) (Year)

7. AGE: Four Hours (.....Yrs.....Mos.....ds.)

IF LESS than 1 day how many.....hrs. or .....min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Coeur d'Alene Idaho

10. NAME OF FATHER F. H. Urmson

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Mary Botkin

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. H. Urmson

(Address) Coeur d'Alene

15.

Filed Sept-9 1916

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 8 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to Sept 8 1916, that I last saw h.. alive on Sept 8 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) J. O'Dwyer M. D.

9/9 1916 (Address) Coeur d'Alene, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetary	Sept. 9 1916
20. UNDERTAKER	ADDRESS
F. E. Kidd	C. D. A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7 15337
Registered No. 8

Registration District No. 29
Primary Registration District No. 1050

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sewert Knudson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 3 (Day) 1859 (Year)

7. AGE: 57 Yrs. 4 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work. Saw Mill Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER Knut Sewerson

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Hattie Igelson

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Hattie Ericksen
(Address) 902 Young Ave

15. Filed Aug 31 1916 — F. Hughes, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1916, to Aug 29 1916, that I last saw him alive on Aug 29 1916, and that death occured on the date stated above, at 5P M.

The CAUSE OF DEATH* was as follows:
Shock and hemorrhage from crushed leg, injured at Rutledge Saw mill.

(Duration) ..... Yrs. ..... mos. 1/2 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. B. Shephard M. D.
(Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Aug 31 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & STNRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
(No. .... St.)

File No. 7 15338
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ellen Robinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb. (Month) 22 (Day) 1856 (Year)

7. AGE: 60 Yrs. 6 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: James Elliot

11. BIRTHPLACE OF FATHER (State or Country): —H—

12. MAIDEN NAME OF MOTHER: Jane Houser

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. T. Robinson
(Address) Coeur D' Alene

15. Filed Sept-2 1916 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1915, to Sept 2 1916, that I last saw her alive on Sept 1 1916, and that death occured on the date stated above, at 7 a. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Rigg M. D.
Sept 19 16 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Sept 3 1916

20. UNDERTAKER: Cassidy & Nelson — ADDRESS: Coeur D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15389

Registered No. 6

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No. 29

Primary Registration District No. 1050

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Dahlgren

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. March 26 1859
(Month) (Day) (Year)

7. AGE: 57 Yrs. 4 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Knut Haaleson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edwin Dahlgren
(Address) Coeur d'Alene

15. Filed 8-17 1916 A. J. Hughe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 16th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10th 1916, to Aug 16th 1916, that I last saw her alive on Aug 10th 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary): Intestinal nephritis

(Duration 5 yrs. — mos. — ds.

(Signed) Jno Bunday M. D.
Aug 17th 1916. (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Boy — DATE OF BURIAL: Aug 18 1916

20. UNDERTAKER: F. E. Hodod — ADDRESS: C. d. A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 15340
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of Amvrace
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jos. Nelson Woods

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: 3 (Month) 22 (Day) 1850 (Year)

7. AGE: 66 Yrs. 4 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Jos. Woods

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Jamison

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Hazel Mount,

15. Filed Aug-20 1916. D Hughes, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw h in alive on April 10 1916, and that death occured on the date stated above, at 9P M.

The CAUSE OF DEATH* was as follows:
Supposed Heart trouble,

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) —

(Duration — yrs. — mos. — ds.

(Signed) W. H. Hoeden M. D.

8/19 1916 (Address) Leonard Alene Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Aug 20 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24659

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

File No. 15341
Registered No. 17

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles H. Clayton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (write the word.): Widower

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 73 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank D. Wood
(Address) Coeur d'Alene

15. Filed Sept-6 1916 O. Bruce Rey Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1915, to Sept 3 1916, that I last saw h[illegible] alive on Sept. 2 1916 and that death occured on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstial Nephritis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. Bruce Rey M. D.

Sept. 4 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Sept. 6 1916

20. UNDERTAKER: T. E. Hedal — ADDRESS: C. D'A.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
(No. ..... St.)

File No. 15342
Registered No. 11

1. PLACE OF DEATH.

County of Kootenai
City of Coeur d'Alene

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa McLaughlin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1830 (Year)

7. AGE: 85 Yrs. ..... Mos. 10 ds. 1

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N. York

10. NAME OF FATHER: Silas Putnam

11. BIRTHPLACE OF FATHER (State or Country): N Y

12. MAIDEN NAME OF MOTHER: [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mable C. Barnes
(Address) Coeur d'Alene Id.

15. Filed Sept 8 1916 — D Hughes, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30 1916, to Sept 5 1916, that I last saw h[illegible] alive on Sept 4 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. — mos. 8 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Vaughn M. D.

Sept 7 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest — DATE OF BURIAL: Sept 8 1916

20. UNDERTAKER: S J Luce — ADDRESS: C W G

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15343
Registered No. .....

1. PLACE OF DEATH.

County of Idaho
City of Whitebird
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. .....
Primary Registration District No. .....

2. FULL NAME Minnie J Ashby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 6 (Day) 1880 (Year)

7. AGE: 36 Yrs. ..... Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Coupon

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Ashby
(Address) Freedom Ida

15. Filed ..... 191.....
W A Forkett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 26 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 191 6, to Aug 191 6, that I last saw h alive on Aug 191 6, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Hemorrhage from lungs
following Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Tuberculosis 4 yrs

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W A Forkett M. D.
Aug 26 1916 (Address) Whitebird Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Freedom Ida
DATE OF BURIAL: Aug 28 1916

20. UNDERTAKER: Hancock
ADDRESS: Grangeville Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho

City of Riggins

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

File No. 15344

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Viola Louella Rape

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 1 (Day) 1912 (Year)

7. AGE: 3 Yrs. 10 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Grangeville Ida

10. NAME OF FATHER: Oscar B Rape

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Mattie Calkins

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M E Rape

(Address) Riggins Ida

15.

Filed ..... 191.....

W A Foskett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from did not attend 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Diptheria

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W A Foskett M. D.

Oct 9 16 (Address) Whitebird Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riggins — DATE OF BURIAL: Aug 20 1916

20. UNDERTAKER: No — ADDRESS: —

SYMS - YORK CO., PTPS. & SPGS. 24653

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

Registration District No. 47

Primary Registration District No. 2116

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15346

Registered No. 28

1. PLACE OF DEATH.

County of Lemhi

City of Salmon

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John F Lambeth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. 65 September 11 (Month) 11 (Day) 1850 22 (Year)

7. AGE: 65 Yrs. 11 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Rancher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Missouria

10. NAME OF FATHER John F Lambeth

11. BIRTHPLACE OF FATHER (State or Country) Missouria

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John F Lambeth Jr
(Address) Salmon Ida

15.
Filed Sept. 5, 1916 Edith D Hendron
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 3rd 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1916, to Sept 3 1916, that I last saw h— alive on Sept 3 1916, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteria Sclerosis

.....(Duration ..... yrs. 2 mos. ..... ds.

(Signed) J A Wright M. D.

9/4 1916 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ REMOVAL: Iron Creek Idaho. DATE OF BURIAL: 9-7" 1916

20. UNDERTAKER: W. C. Hoobler ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 8-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 41

County of Lemhi

Primary Registration District No. 2116

File No. 15347

City of Salmon (No. ..... St.)

Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Anna Ingals

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Married

6. DATE OF BIRTH. Do not know
(Month) (Day) (Year)

7. AGE 69 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Do not know

10. NAME OF FATHER " " "

11. BIRTHPLACE OF FATHER (State or Country) " " "

12. MAIDEN NAME OF MOTHER " " "

13. BIRTHPLACE OF MOTHER (State or Country) " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Elizabeth Clark
(Address) Leadore, Ida.

15. Filed Aug 23 1916 Ed D Henderson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 22nd 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1916, to Aug 22 1916, that I last saw her alive on Aug 22 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration 2 yrs. 2 mos. ..... ds.

(Signed) F. J. Wright M. D.

8/23 1916 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State [redacted] .....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Salmon City Cemetery — DATE OF BURIAL 8-23rd 1916

20. UNDERTAKER W C Loebbe — ADDRESS Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15348

Registered No. 26

1. PLACE OF DEATH.

County of Lemhi

City of Northfork Ida.

(No. ; St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41

Primary Registration District No. 2116

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vivian Hovey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. September 21st 1894 (Month) (Day) (Year)

7. AGE: 21 Yrs. 11 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: C. B. Hovey

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Emma Aburg

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C B Hovey

(Address) Northfork Ida.

15. Filed Sept 24 1916 E D Thrunden Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 22nd 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h...alive on ..... 191...,

and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

By Means of a Gunshot Wound By the Hand of Stonewall Bellenger

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W C Doeble Coroner M. D.

8-23rd 1916 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~CREMATION~~ DATE OF BURIAL

Salmon City Cemetery 8-24th 1916

20. UNDERTAKER: W C Doeble ADDRESS: Salmon Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 73

Primary Registration District No. 2371

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15349

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Melrose

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Susie Bellman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 11 (Day) 1882 (Year)

7. AGE: 34 Yrs. 4 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Missouria

10. NAME OF FATHER J B Bell

11. BIRTHPLACE OF FATHER (State or Country) Kentuckey

12. MAIDEN NAME OF MOTHER Mary J McClure

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M J Bell

(Address) P.O. Melrose

15. Filed 8-4 1916

J M Lyle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8 1916, to Aug 2 1916, that I last saw her alive on Aug 2 1916, and that death occured on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J M Lyle M. D.

8-3 1916 (Address) Peck Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Melrose Ida — DATE OF BURIAL: 8-4 1916

20. UNDERTAKER: Stoddard — ADDRESS: Gifford Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15350

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Peck

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Eletha Pearson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. October (Month) 16 (Day) 1836 (Year)

7. AGE: 79 Yrs. 10 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Solomon Edes

11. BIRTHPLACE OF FATHER (State or Country) U. S.

12. MAIDEN NAME OF MOTHER Susanah Collett

13. BIRTHPLACE OF MOTHER (State or Country) U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T M Pearson

(Address) Peck Idaho

15. Filed 8-11 1916

J M Lyle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

..... (Month) ..... (Day) 191..... (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Peck Idaho

DATE OF BURIAL: 8-12 1916

20. UNDERTAKER: Moore

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH 28

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15351

Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls.
City of Filer
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. 2086

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Howard Vining.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Feb (Month) 16 (Day) 1912 (Year)
7. AGE: 4 Yrs. 6 Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Farming
9. BIRTHPLACE (State or Country) Idaho.
10. NAME OF FATHER Lee Vining
11. BIRTHPLACE OF FATHER (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Mary Syle
13. BIRTHPLACE OF MOTHER (State or Country) Mich.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Filer Ida
(Address) E A Vining
15. Filed 8/22 1916 A. O. Newhouse Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 20 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 18 1916, to Aug 20 1916, that I last saw h[illegible] alive on Aug 19. 1916, and that death occured on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:
Endocarditis
(Duration) ..... Yrs. ..... mos. 2 days.
Contributory (Secondary) Rheumatism
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. W. Gemmis M. D.
Aug 22 1916 (Address) Filer Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer I. O. O. F. DATE OF BURIAL: Aug. 22 1916
20. UNDERTAKER: Freeman & Evans ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH 38

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. 2086
File No. 15352
Registered No. ____

1. PLACE OF DEATH.
County of Twin Falls
City of Twin
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Raymond Vining

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Aug. (Month) 24 (Day) 1913 (Year)
7. AGE: 3 Yrs. 0 Mos. 6 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: ____
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Lee Vining
11. BIRTHPLACE OF FATHER (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Mary Pyle
13. BIRTHPLACE OF MOTHER (State or Country): Ill
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E A Vining
(Address) Twin
15. Filed ____ 191__ A A Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 30 (Day) 191 6 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 14th 1916, to Aug 30 1916, that I last saw h[im] alive on Aug 29 1916, and that death occured on the date stated above, at ____ M.
The CAUSE OF DEATH* was as follows:
Acute Dilitation of Heart
(Duration) ____ Yrs. ____ mos. 1 ds.
Contributory (Secondary) Pneumonia Meningitis
(Duration ____ yrs. ____ mos. 26 ds.
(Signed) Duncan Peterson Jr M. D.
8/31 1916 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin I.O.O.F. — DATE OF BURIAL: Sept. 1 191 6
20. UNDERTAKER: Freeman & Evans — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOS. 24658

FORM V. S. No. 5-27 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15353

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. ..... St.)

2. FULL NAME Infant Simms

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 2 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James Simms

11. BIRTHPLACE OF FATHER (State or Country): Miss.

12. MAIDEN NAME OF MOTHER: Fridelia Dickerson

13. BIRTHPLACE OF MOTHER (State or Country): Miss.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs James Simms

(Address) Twin Falls

15. Filed 8. 27. 1916. John F Coughlin Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27, 1916, to Aug 27 1916, that I last saw h[illegible] alive on Aug 27 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth

Marasmus

8 hrs.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Pike M. D.

8/31/1916 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Aug 28 1916

20. UNDERTAKER: Grossman & Ernst — ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15354

Registered No. .....

Registration District No. 37

Primary Registration District No. 1085

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew W McDougal

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Aug. (Month) 30 (Day) 1855 (Year)

7. AGE: 60 Yrs. 11 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Lloyd McDougal.

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Nancy Lawrence

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Bertha McDougal
(Address) Twin Falls Ida.

15.
Filed 8 13. 1916
John F Lovald
Local Registrar

SYMS - YORK CO., PTRS. & BKBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11, 1916, to Aug 13 1916, that I last saw h[im] alive on Aug 5 1916, and that death occured on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Mitral & Aortic regurgitation incompensated - Chronic Nephritis

(Duration 4 yrs. ..... mos. ..... ds.

(Signed) Duncan K Abraham M. D.

Aug 16 1916. (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Aug 14 1916

20. UNDERTAKER: Gooding & Ewer — ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15355

Registered No. .....

1. PLACE OF DEATH

County of Twin Falls

Registration District No. 37

Primary Registration District No. 1085

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Irmen Williamson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): —

6. DATE OF BIRTH. Sept 20 (Month) (Day) 1913 (Year)

7. AGE: 2 Yrs. 11 Mos. 11 ds.

IF LESS than 1 day how many .....hrs. or .....min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: A. Williamson

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Harriett Evans

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alva Williamson

(Address) Twin Falls

15.

Filed Sept 1 1916

John F Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 16 1916, to Aug 31 1916, that I last saw him alive on Aug 31 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

.....(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) Bronchial Pneumonia

.....(Duration ..... yrs. ..... mos. 3 ds.

(Signed) Milton E. Corbin M. D.

19..... (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL 9-2 1916

20. UNDERTAKER: E J Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24652

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 15356
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Kimberly
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph Steavens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May 4th 1862
(Month) (Day) (Year)

7. AGE: 54 Yrs. 2 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: X X Steavans

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. M. J. Steavens
(Address) Twin Falls Idaho

15. Filed 7-14 1916 John T. Eagleson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
7 - 10 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1916, to July 10 1916, that I last saw him alive on July 10 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Pericarditis - Double Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Acute Rheumatic infection
(Duration ..... yrs. ..... mos. 6 ds.

(Signed) Duncan L Alexander M. D.
7/14 1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 7-13 1916

20. UNDERTAKER: C J Crosby
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 15357
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Kimberly
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Curtis M. Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH. November 4 (Month) (Day) 1852 (Year)

7. AGE 63 Yrs. 7 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER Hiram Pritchell

11. BIRTHPLACE OF FATHER (State or Country) Maine

12. MAIDEN NAME OF MOTHER Maria Dodge

13. BIRTHPLACE OF MOTHER (State or Country) Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Maud Williams
(Address) Kimberly, Idaho

15. Filed 7-14 1916 John H. Coggeshall Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 2nd (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h.....alive on ..... 191...,
and that death occured on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:

Apoplexy

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Brights Disease
.....(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C J Crosby Coroner M. D.
19.... (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls — DATE OF BURIAL 7-5 1916

20. UNDERTAKER C J Crosby — ADDRESS T Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of
(No. , St.)

Registration District No. 37
Primary Registration District No. 2085
File No. 15358
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel P. Christensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Married (Write the word.)

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE About
33 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Traveling Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Marenius Christensen

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Anna Petersen

13. BIRTHPLACE OF MOTHER (State or Country) Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. Jensen
(Address) Sandy Utah

15.
Filed 8 12 1916 John F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 9th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 , to 191 , that I last saw h alive on 191 , and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Drowning

(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) Charles J Crosby M. D.
19 (Address) Twin Falls Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs mos days. In the State yrs mos days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL
Sandy City Utah | Aug 13 1916

20. UNDERTAKER | ADDRESS
Twin Falls Ida | Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 15359
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME T. Thomas Hamill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1 (Year)

7. AGE
38 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Homesteader & ...
(b) General nature of industry, business, or establishment in which employed (or employer)..... Teacher

9. BIRTHPLACE (State or Country): Supposed to be Tenn

10. NAME OF FATHER: Hamill

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. Crosby
(Address) Twin Falls Coroner

15.
Filed 6 21 1916
John J. Naughton
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 - 15 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Murdered by shot gun in hands of Lynn Loveacre
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. J. Crosby Coroner
19... (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ligonier Tenn — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: C. Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of ..... — Primary Registration District No. 2085.

(No. ....., ... St.)

File No. 15360

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sy Joseph Spencer White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 26 (Day) 1887 (Year)

7. AGE: 29 Yrs. X Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Structural
(b) General nature of industry, business, or establishment in which employed (or employer): Iron Worker

9. BIRTHPLACE (State or Country): Arizona

10. NAME OF FATHER: Hiram White

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Lydia Wallace

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Sy White
(Address) Salt Lake City

15. Filed 8 — 12 191 6 — John L. Coughlan, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July Aug (Month) 12 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Fell from Steel work (56 ft.) of new beet sugar factory

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas J Crosby M. D.
8-17 1916 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake — DATE OF BURIAL: 8-14 191 6

20. UNDERTAKER: C J Crowley — ADDRESS: T Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 15361
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eunice A. Boone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widowed

6. DATE OF BIRTH.
August (Month) 23 (Day) 1841 (Year)

7. AGE
74 Yrs. 10 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Ohio.

10. NAME OF FATHER Silas Tefvon.

11. BIRTHPLACE OF FATHER
(State or Country) Hebron Connecticut

12. MAIDEN NAME OF MOTHER Mary Reed Benedict

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. C. Boone
(Address) Twin Falls Ida

15.
Filed 7-10 1916 John W. Eagle
Local Registrar

SYMS - YORK CO., PTRS. & BKBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
7 - 9 - 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from by post mortem 1916, to July 10 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis

Several
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. G. Fike M. D.
7/10/1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 7-10 1916

20. UNDERTAKER: C. J. Crosby
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15362

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of Twin Falls

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

2. FULL NAME Beulah McMaster

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH. March (Month) 3 (Day) 1900 (Year)

7. AGE: 16 Yrs. 3 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Buford Ida.

10. NAME OF FATHER: John M. McMaster

11. BIRTHPLACE OF FATHER (State or Country): Buford Ida.

12. MAIDEN NAME OF MOTHER: Mattie Parker.

13. BIRTHPLACE OF MOTHER (State or Country): Hopkins Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. M. McMaster
(Address) .....

15. Filed 7. 19. 1916 John F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1916, to July 18 1916, that I last saw her alive on July 18 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Effensive burns, caused by gasoline explosion

(Duration) Yrs. ..... mos. ..... ds.

Contributory (Secondary) after absorbtine

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. E. Schwartz M. D.

7/18 19 16 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 3 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Kimberley Idaho

Former or usual residence Kimberley Idaho.

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: July 20th 1916

20. UNDERTAKER: Grossman and Ewel. ADDRESS: Twin Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & PUBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15363

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 37

Primary Registration District No. 1085

County of Twin Falls

City of " "

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Opal Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. (Month) 9 (Day) 1900 (Year)

7. AGE: 15 Yrs. 9 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School girl.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Colorado

10. NAME OF FATHER Chas. W Clark.

11. BIRTHPLACE OF FATHER (State or Country) Canada.

12. MAIDEN NAME OF MOTHER Carrie Shirbon

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas. W. Clark
(Address) Twin Falls

15. Filed 7. 27. 1916 John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7:15 P.M. July (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1916, to July 26 1916, that I last saw h. alive on July 26 1916, and that death occured on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:
Streptococcus infection resulting in endocarditis and Chorea

(Duration) ..... Yrs. ..... mos. 23 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Coughlin, M. D.
July 28 1916 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: July 28 1916

20. UNDERTAKER: Goodman & Evans — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOK. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 15364
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jas. Cecil Stanger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Jan 28 (Month) (Day) 1897 (Year)
7. AGE: 19 Yrs. 5 Mos. 28 ds. IF LESS than 1 day how many .....hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Idaho
10. NAME OF FATHER Geo. W. Stanger
11. BIRTHPLACE OF FATHER (State or Country) Utah
12. MAIDEN NAME OF MOTHER Sarah Ellen Knight
13. BIRTHPLACE OF MOTHER (State or Country) Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. P. Stanger
(Address) American Falls Ida
15.
Filed 7-29-1916 John F. Caufield Local Registrar

SYMS - YORK CO., PTRS. & BKBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 27 (Month) (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 22 1916, to July 26 1916, that I last saw h alive on July 26 1916, and that death occured on the date stated above, at 2-45 a M.
The CAUSE OF DEATH* was as follows:
Typhoid Fever
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Heart Complication
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. A. Newberry M. D.
.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: American Falls — DATE OF BURIAL: 7-30 1916
20. UNDERTAKER: C J Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15365

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Twin Falls

City of .....

Registration District No. 37

Primary Registration District No. 1085

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Abt.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 28 (Day) 1867 (Year)

7. AGE: 48 Yrs. 7 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mont.

10. NAME OF FATHER Frank Abt.

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Mary Distel

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Alice Abt
(Address) Twin Falls Ida

15. Filed 7. 26 1916. John F. Coughlin Local Registrar

SYMS - YORK CO., PTRS. & BKBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1915, to July 24 1916, that I last saw h[im] alive on July 24 1916, and that death occured on the date stated above, at 1.10 p M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration 3 Yrs, 7 mos. ds.

Contributory (Secondary) Deleroius Spinal Cord.

(Duration 2 yrs. 8 mos. ds.

(Signed) D.M. Reynolds M. D.

7/26 1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Cemetery — DATE OF BURIAL: July 27 1916

20. UNDERTAKER: Grossman & Evans — ADDRESS: Twin Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15366

Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085.

2. FULL NAME Dorothea Jane Walker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept 24 (Month) (Day) 1891 (Year)

7. AGE: 24 Yrs. 8 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Frank J. Clarke

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Georgia Walrath

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Clyde C. Walker
(Address) Hansen Ida.

15. Filed 7-4 1916 J. E. Crighton Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
7 (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1916, to July 4 1916, that I last saw her alive on July 4 1916, and that death occured on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:
Peritonitis
following appendicitis & perforated gut.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pericardial attacks
(Duration 15 yrs. ..... mos. ..... ds.
(Signed) John R Morgan M. D.
7-4 1916 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Augusta Wisconsin — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Goodenough & Eaves — ADDRESS: Twin Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1083
(No. ..... St.)

File No. 15367
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Glenn V. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant.

6. DATE OF BIRTH. Sept. (Month) 13 (Day) 1915 (Year)

7. AGE: ..... Yrs. 11 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Stafford Co. Kansas.

10. NAME OF FATHER: Arthur D. Smith.

11. BIRTHPLACE OF FATHER (State or Country): Kentucky.

12. MAIDEN NAME OF MOTHER: Ella M. Smith.

13. BIRTHPLACE OF MOTHER (State or Country): Stafford Co. Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arthur D. Smith
(Address) Twin Falls Ida.

15. Filed 8 17 1916 John F Caughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 9. 16 1916, to Aug. 16 1916, that I last saw h.. alive on Aug. 17 1916 and that death occured on the date stated above, at 12:10 P.M.

The CAUSE OF DEATH* was as follows:
Acute Gastro-enteritis.
Pulmonary oedema.
(Duration) ..... Yrs. ..... mos. 9 hrs. ..... ds.
Contributory (Secondary) Convulsions
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John F Caughlin M. D.
8/17 1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho. DATE OF BURIAL: Aug 18th 1916

20. UNDERTAKER: Grossman & Ennes. ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-35 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 125

Primary Registration District No. 2203

File No. 15369

County of Fremont

City of Dubois (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 18 (Day) 1916 (Year)

7. AGE: ..... Yrs. 2 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Dubois Idaho

10. NAME OF FATHER Nathan E Reynolds

11. BIRTHPLACE OF FATHER (State or Country) N C

12. MAIDEN NAME OF MOTHER Jennie M Milnes

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nathan E Reynolds

(Address) Humphrey Idaho

15. Filed Sept. 16 1916 C E Jones M D Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1916, to Sept 13 1916, that I last saw h[illegible] alive on Sept 13 1916 and that death occured on the date stated above, at 12:55 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) C E Jones M. D.

9-14 1916 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dubois Idaho — DATE OF BURIAL: 9-14 1916

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 125
Primary Registration District No. 2203
(No. ..... St.)

File No. 15370
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of Winsper
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth L Flint

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. March (Month) 18 (Day) 1913 (Year)

7. AGE: 3 Yrs. 5 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Port Falls Idaho

10. NAME OF FATHER Samuel J Flint

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Nellie E Bailey

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Samuel J Flint
(Address) Winsper Idaho

15. Filed Sept 5 1916 — C E Jones M D, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 1916, to Sept 4 1916, that I last saw h[illegible] alive on Sept 4 1916, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Entero-colitis

.....(Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary) .....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C E Jones M. D.
9-5- 1916 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dubois Idaho
DATE OF BURIAL: Sept 6 1916

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

OVER - YORK CO. PTRS. & STNR. 24955

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 18
Primary Registration District No. 2102
File No. 15372
Registered No. 9

1. PLACE OF DEATH.
County of Minidoka
City of Burley,
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herbert Kimmerling.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. (Month) 22 (Day) 1880 (Year)

7. AGE: 36 Yrs. 5 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rockford Ohio.

10. NAME OF FATHER: Benjamin F. Kimmerling.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Mary E. Birch.

13. BIRTHPLACE OF MOTHER (State or Country): Lima Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. A. Kimmerling
(Address) Heyburn Ida.

15.
Filed Sept 19 1916
V. R. Kilts
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 27th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1916, to Aug. 27th 1916, that I last saw him alive on Aug. 26th 1916, and that death occured on the date stated above, at 6.45a M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Trouble.
Chronic Nephritis.

(Duration) Several Yrs. mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) J. C. Patterson M. D.
9-21 1916 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Heyburn Ida. DATE OF BURIAL: 9/28/1916

20. UNDERTAKER: J. J. Gallogly. ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15373

Registered No.

1. PLACE OF DEATH. Registration District No. 35

County of Elmore Primary Registration District No. 35 2021

City of Glenn's Ferry (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia A. Kruse.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: September 6. (Month) (Day) 1853 (Year)

7. AGE: 62 yrs. 11 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework or Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Jacob. Stein

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Mary. Flander.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Stein
(Address) Glenn's Ferry Idaho.

15.
Filed Sept. 4th 1916. J. W. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 2nd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 22nd 1916, to September 2nd 1916 that I last saw her alive on September 2nd 1916, and that death occurred on the date stated above, at 6 15 A. M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. 2 hrs ds.

Contributory (Secondary): Embolus or Thrombus not known

(Duration) yrs. mos. ds.

(Signed) J. W. Davis M. D.

Sept. 2nd 1916 (Address) Glenn's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sept. 4th. Glenn's Ferry Idaho | DATE OF BURIAL: Sept. 4th 1916

20. UNDERTAKER: J. M. Cowan | ADDRESS: Mountain Home Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15374

Registered No. .....

1. PLACE OF DEATH.

County of Latah.

City of Potlatch

Registration District No. 65.

Primary Registration District No. 2145.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Son of John. Stith.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH. Sept. (Month) 30. (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... -

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER John. Stith.

11. BIRTHPLACE OF FATHER (State or Country) Ky.

12. MAIDEN NAME OF MOTHER Lusindy Roach.

13. BIRTHPLACE OF MOTHER (State or Country) Minnesota.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Stith.

(Address) Potlatch.

15. Filed Sept. 30 1916 .....

Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 30 1916, to Sept. 30 1916, that I last saw him alive on Sept. 30 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature birth.

.....

.....

.....(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Thompson. M. D.

9/30. 1916 (Address) Potlatch Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery.

DATE OF BURIAL: Sept. 30 1916

20. UNDERTAKER: Parents.

ADDRESS: Potlatch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15375

Registered No. 227

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. ....., ... St.)

2. FULL NAME Nina Violet Kelly,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Feb. 20. 1916
(Month) (Day) (Year)

7. AGE: 0 yrs. 6 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Owyhee Co. Idaho.

10. NAME OF FATHER: P. W. Kelly.

11. BIRTHPLACE OF FATHER (State or Country): Canada,

12. MAIDEN NAME OF MOTHER: Laura May Cox

13. BIRTHPLACE OF MOTHER (State or Country): Nampa Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P W Kelly
(Address) Wilson, Idaho.

15. Filed 9/30 1916 E J Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 28 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1916, to Aug 28 1916 that I last saw her alive on Aug 28 1916, and that death occurred on the date stated above, at 7.30 P. M.

The CAUSE OF DEATH* was as follows:
Intestinal intussusception
forth operation.

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary): None.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. P. Ross M. D.
Aug 28 1916 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilson Idaho.
DATE OF BURIAL: Aug 30 1916

20. UNDERTAKER: F. K. Robinson
ADDRESS: Nampa, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 15376

Registered No. 226

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 208 W. Jefferson St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harold Auten

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6. DATE OF BIRTH. (Month) Sept (Day) 15 (Year) 1916

7. AGE ... Yrs. ... Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Boise, Ida.

10. NAME OF FATHER Jas Auten

11. BIRTHPLACE OF FATHER (State or Country) Kansas.

12. MAIDEN NAME OF MOTHER Sybia Ingraham

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Auten

(Address) Boise, Idaho

15. Filed 9/29 1916

E J Cotton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 29th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 29th 191.., to Sep 29th 1916, that I last saw him alive on Sept 29th 1916, and that death occured on the date stated above, at 2 20 P.M.

The CAUSE OF DEATH* was as follows:

Heart failure

caused by Atelectasis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Acute Colitis

(Duration ... yrs. ... mos. ... ds.

(Signed) John Baum M. D.

9/29 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL Harris Hill Cemetery — DATE OF BURIAL 9/29 1916

20. UNDERTAKER Schreiber & Sidenfaden — ADDRESS Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada
City of Boise
(No. 412 State St.)

Registration District No. 2
Primary Registration District No. 1004

File No. 15377
Registered No. 225

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orlan Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept 11 (Month) (Day) 1889 (Year)

7. AGE: 27 Yrs. 0 Mos. 14 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: J W. Lee

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Martha Stewart

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)
(Address) J W Lee Ex. Boise Idaho

15. Filed 9/26 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 1916, to Sep 27 1916, that I last saw h[illegible] alive on ..... 191..., and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Cancer of bowels

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M Calvert M. D.
9/26 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Sept 27 1916

20. UNDERTAKER: Gray & Summers | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15378
Registered No. 216

1. PLACE OF DEATH.

County of Ada
City of Boise
(No. 110 East Bannock St.)
Registration District No.
Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 14 (Day) 1916 (Year)

7. AGE: .....Yrs. .....Mos. 1 ds.
IF LESS than 1 day how many .....hrs. or .....min.

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: A. C. Phillips

11. BIRTHPLACE OF FATHER (State or Country): Ogden Utah

12. MAIDEN NAME OF MOTHER: Kitty M. Leonard

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Adlai C. Phillips
(Address) Boise, Idaho

15.
Filed .....191....
E. J. Cator
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 14 1916, to Sep 16 1916, that I last saw him alive on Sep 16 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Premature Birth

.....(Duration) .....Yrs. .....mos. 2 ds.
Contributory (Secondary) .....
.....(Duration) .....yrs. .....mos. .....ds.

9/16 1916 (Signed) C. W. Toncray M. D.
(Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos. 1 days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Sept 17 1916

20. UNDERTAKER: Schneider & Sidinfoden | ADDRESS: Boise

Torres.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15379
Registered No. 215

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 412, State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Garfield Trask

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 12 (Day) 1887 (Year)

7. AGE: 29 Yrs. 1 Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mechanical
(b) General nature of industry, business, or establishment in which employed (or employer): Engineer

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: R. D. Trask

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Ina M Shubert

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ray H Trask
(Address) Boise, Ida

15. Filed ..... 191.....
E. L. Caton
Local Registrar

SYMS - YORK CO., PTRS. & RORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1916, to Sept 12 1916, that I last saw h[illegible] alive on Sept 12 1916, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Typhoidis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Myocarditis with auricular fibrillation
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Maurice T Tallman M. D.
19.... (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Sept 17 1916

20. UNDERTAKER: Frye & Summers | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15381
Registered No. 223

1. PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 2004
(No. 319 West Jefferson St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Archie H Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: Nov (Month) 24 (Day) 1858 (Year)

7. AGE: 58 Yrs. 9 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranchman
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Hughs Clark.

11. BIRTHPLACE OF FATHER (State or Country): Prince Edw Island

12. MAIDEN NAME OF MOTHER: Mary Gamble.

13. BIRTHPLACE OF MOTHER (State or Country): Prince Edw Island

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frances Clark
(Address) .....

15. Filed 9/22 1916 — E. H. Eaton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30 1916, to Sept. 21 1916, that I last saw him alive on Sept 21 1916, and that death occured on the date stated above, at 10 30 P.M.

The CAUSE OF DEATH* was as follows:
Malignant Neoplasm of the Bronchial tube

(Duration) One Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Kingsbury M. D.
19 ..... (Address) 404 Idaho Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Sep 23 1916

20. UNDERTAKER: Frey & Summers Co. — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15382
Registered No. 222

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 112 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H. Hart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. June (Month) (Day) 1840 (Year)

7. AGE: 76 Yrs. 3 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Attorney at Law
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York City

10. NAME OF FATHER: James Hart

11. BIRTHPLACE OF FATHER (State or Country): Ire.

12. MAIDEN NAME OF MOTHER: Mildred Rosick

13. BIRTHPLACE OF MOTHER (State or Country): Ire.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. L. Hart
(Address) Boise Ida

15.
Filed 9/22 1916
E. F. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 20th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1916, to Sept 20 1916, that I last saw h alive on Sept 20 1916 and that death occured on the date stated above, at 3. P. M.

The CAUSE OF DEATH* was as follows:
Cardiac Dilitation

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)
Duration yrs. mos. ds.

(Signed) [illegible] M. D.
19 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Payne Idaho.

19. PLACE OF BURIAL OR REMOVAL: Nampa, Idaho — DATE OF BURIAL: 9/23 1916

20. UNDERTAKER: Schreiber & Siedenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15383
Registered No. 221

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1109 W. Spring Ave St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christopher Wilkinson Moore

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
3.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. November (Month) 30 (Day) 1835 (Year)

7. AGE: 80 Yrs. 9 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Banker
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Toronto, Ontario Canada

10. NAME OF FATHER: Christopher

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Eliza Crawford

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J W Cunningham
(Address) Boise Idaho

15. Filed 9/22 1916 E. H. Eaton Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 20th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1916, to — 191—, that I last saw h.m alive on Sep 26 1916, and that death occured on the date stated above, at 2. P. M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris.

(Duration) 6/12 hours. mos. ds.
Contributory (Secondary) Hardening of coronary arteries. (Duration — yrs. — mos. — ds.

(Signed) L. P. McCalla M. D.
9/21 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/22 1916

20. UNDERTAKER: Schreiber & Siedenfaden — ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15384
Registered No. 220

1. PLACE OF DEATH.

County of Ada
City of Boise
(No. 622 Idaho St.)

Registration District No. 2
Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wong Kin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1870 (Year)

7. AGE: 46 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: not obtainable

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas Ley Singlee
(Address)

15. Filed Sept 21 1916 — E. F. Eaton, Local Registrar

SYMS - YORK CO. PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 19 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep. 8 1916, to Sep 19 1916, that I last saw him alive on Sep 19 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary): Ruptured appendix

(Duration) yrs. mos. ds.

(Signed) W. W. Tomey M. D.

9/V 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chinese Cemetery — DATE OF BURIAL: 9/21 1916

20. UNDERTAKER: Schreiber & Siderfeden — ADDRESS: Boise Ida

Dr. Tomey

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15385
Registered No. 219

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1709 W. State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna F. Fairchild

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 13th (Day) 1869 (Year)

7. AGE: 47 Yrs. — Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Granite Boise County Idaho

10. NAME OF FATHER: Peter C. Connaughton

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Margt Mc Carty

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas E Fairchild
(Address) Placerville Ida

15.
Filed Sept 21 1916
E. F. Eaton Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 19th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/17 1916, to 9/17 1916, that I last saw h[illegible] alive on 9/19 1916, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Apoplexy Cerebral Hemorrhage
Duration of Coma
(Duration) 10 Yrs. or more ds.
Contributory (Secondary)
(Duration yrs. mos. 30 ds.
(Signed) James L Stewart M. D.
9/20 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Placerville Ida — DATE OF BURIAL: 9/21 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

Dr. Stewart

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15886

Registered No. 218

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 317 Grove St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Whitta

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Not Obtainable (Month) (Day) 1866 (Year)

7. AGE 50 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Miner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Rodda

(Address) Boise Ida

15. Filed Sept 20 1916 — E. F. Eaton, Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased from Sept 19 1916, to ..... 191..., that I last saw him ~~alive~~ on Sept 19 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

He was found dead in bed

Chronic (Duration) 10 yrs. mos. ds.

Contributory (Secondary) Was under attending Phys and had not seen him for many

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner M. D.

9/20 1916 (Address) Boise Idaho Ada Co

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery — **DATE OF BURIAL** Sept 21 1916

20. UNDERTAKER Troy Summers — **ADDRESS** Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15687
Registered No. 217

1. PLACE OF DEATH.

County of Ada
City of Boise
(No. 1120 Grove St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jonas W. Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower (Write the word.)

6. DATE OF BIRTH. June 27 (Month) 1 (Day) 825 (Year)

7. AGE 91 Yrs. 2 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Samuel Brown

11. BIRTHPLACE OF FATHER (State or Country) Mass

12. MAIDEN NAME OF MOTHER Lydia Warren

13. BIRTHPLACE OF MOTHER (State or Country) Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. L. Bruce

(Address) Boise Idaho

15.

Filed ..... 191....

E. F. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1916, to Sept 15 1916, that I last saw h alive on Sept 15 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Contributory Cancer Factors

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Coffyn M. D.

Sept 15 1916. (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Masonic Cemetery — **DATE OF BURIAL** Sept 19 1916

20. UNDERTAKER Frye & Summers — **ADDRESS** Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SOBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15388
Registered No. 213

1. PLACE OF DEATH.

County of Ada
City of Boise (No. 6½ N. Grove St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo. Schimpf

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Male	White	Widower

6. DATE OF BIRTH. Oct. (Month) ... (Day) 1846 (Year)

7. AGE 69 Yrs. 11 Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Hessen Darmstadt Germany

10. NAME OF FATHER Geo. Schimpf

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Margaret Gumz

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sadie White

(Address)

15. Filed ... 191...

E. L. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 12 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased from May 15 1916, to Sept 12 1916, that I last saw h~~im~~ alive on Sept 12 1916, and that death occured on the date stated above, at about 6 A.M.

The CAUSE OF DEATH* was as follows: Found him dying on bed when I called him to breakfast. Had no time to call doctor.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed)

19... (Address) Frank Chod. Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery | **DATE OF BURIAL** Sept 13 1916

20. UNDERTAKER Schreiber & Sidenfaden | **ADDRESS** Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada — Registration District No. 2

City of Boise — Primary Registration District No. 1004 — File No. 15389

(No. 110 East Bannock St.) — Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edson Donavan Elliott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Aug (Month) 6 (Day) 1858 (Year)

7. AGE: 58 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: Albert Elliott

11. BIRTHPLACE OF FATHER (State or Country): N. York

12. MAIDEN NAME OF MOTHER: Mrs Elizabeth

13. BIRTHPLACE OF MOTHER (State or Country): Ann

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jno Elliott
(Address) Boise

15. Filed ..... 191.....

E. L. Caton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1916, to Sept 10 1916, that I last saw h— alive on Sept 9 1916, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) Yrs. 9 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Shuntz M. D.

1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Soldiers Home

Former or usual residence Meridian

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept 1916

20. UNDERTAKER: Schreiber & Hodgins — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 15390

Registered No. 211

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Nevins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unknown (Month) (Day) (Year)

7. AGE: ..... Yrs. Unknown Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): U. S.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ralph Nevins
(Address) Boise

15. Filed ..... 191.....
E. J. Cater
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/1 1916 to 9/10 1916
that I last saw him alive on 9/10 1916
and that death occured on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ralph Nevins M. D.
9/11 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. Johns Cemetery — DATE OF BURIAL: Sept 12 1916

20. UNDERTAKER: Schreiber & Siebenladen — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - VOIGT CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15391
Registered No. 210

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Morris Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 7 (Day) 1 (Year)

7. AGE: 54 Yrs. 4 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stock Man
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Morris Evans

11. BIRTHPLACE OF FATHER (State or Country): Ann.

12. MAIDEN NAME OF MOTHER: A. Jett

13. BIRTHPLACE OF MOTHER (State or Country): Ann.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. C. Evans.
(Address) Eagle.

15. Filed 191
E. F. Caton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 7th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1916. to Sept 7 1916.,
that I last saw h alive on Sept 7 1916.,
and that death occured on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:-
accidental injuries

(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) J. S. Springer M. D.
Sept 7 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days
Where was disease contracted if not at place of death?
Former or usual residence Eagle Ida

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept. 10 1916

20. UNDERTAKER: Schneider & Hidenfeldt — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24958

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15392
Registered No. 209

1. PLACE OF DEATH.
County of Ada
City of Boise.
(No. ——, ——— St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennie M. McKee.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): W

6. DATE OF BIRTH.
— (Month) — (Day) 1848 (Year)

7. AGE
68 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE
(State or Country) Penn.

10. NAME OF FATHER
Joseph Mc Kee.

11. BIRTHPLACE OF FATHER
(State or Country) Penn.

12. MAIDEN NAME OF MOTHER
Not Obtainable

13. BIRTHPLACE OF MOTHER
(State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W S Peters
(Address) Boise

15.
Filed ——— 191—
E. L. Carter
Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept 7 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1916, to Sept 7 1916, that I last saw h-er alive on Sept 8 1916, and that death occured on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:
Burned

(Duration) ——— Yrs. ——— mos. 1 ds.

Contributory (Secondary)
(Duration) ——— yrs. ——— mos. ——— ds.

(Signed) W S Peters M. D.
8-8 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
In this place ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Sep 9 1916

20. UNDERTAKER: Fry & Summers ADDRESS: Boise Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 15393

Registered No. 208

County of Ada

City of Boise (No. 110 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evelyn Mc Hendershot

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Sept (Month) 2nd (Day) 1860 (Year)

7. AGE: 56 Yrs. 10 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: D. Reed Ferguson

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Susan E. Strong

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ralph B. Hendershot

(Address) 614 No 9th.

15. Filed 9/7 191.....

E. F. Coltrin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 6 (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10th 1916, to Sept 6th 1916, that I last saw her alive on Sept 6th 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia.

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) W. B. Smith M. D.

9/7 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Sept. 8 1916

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24053

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15394

Registered No. 207

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oliver Abraham Duquette

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Oct. (Month) 17 (Day) 1839 (Year)

7. AGE: 76 Yrs. 10 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Mr. Duquette

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Abraham Duquette

(Address) Hailey Idaho

15.

Filed ..... 191..

E. F. Colvin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1916, to Sept 5 1916, that I last saw him alive on Sept 5 1916 and that death occured on the date stated above, at 2P M.

The CAUSE OF DEATH* was as follows:

Fecal infarction

Febris colo

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. H. Talleman M. D.

9/5 1916 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days

St Alphonsus Hosp.

Where was disease contracted if not at place of death?

Former or usual residence Idaho City, Idaho

19. PLACE OF BURIAL OR REMOVAL: Idaho City Idaho

DATE OF BURIAL: 10/ 191..

20. UNDERTAKER: Schreiber & Sidenfaden

ADDRESS: Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15395
Registered No. 205

Registration District No. 2
Primary Registration District No. 1004

1. PLACE OF DEATH.
County of Ada
City Boise
(No. 2414 W. Resseguie St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Patricia Hanratty
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. (Month) 8 (Day) 1903 (Year)

7. AGE: 12 Yrs. 9 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Parsons

10. NAME OF FATHER: Patrick Hanratty

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Mary Jane Lawler

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P. Hanratty
(Address) Boise, Idaho.

15. Filed 9/3 1916 E. C. [illegible] Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 3rd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1916, to Sept 3 1916, that I last saw h.. alive on Sept 2 1916, and that death occured on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Acute nephritis
(Duration) Yrs. 2 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. H. Dalman M. D.
9/4 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: Sept. 4 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

Tillman

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 15396

Registered No. 206

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 1116 River St. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occu away from usual residence, give facts called for under special information.

2. FULL NAME Mina Fletcher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 4 (Day) 1915 (Year)

7. AGE: 1 Yrs. 7 Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Walter Fletcher

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Flora Cole

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Walter Fletcher
(Address): .....

15. Filed 9/5 191 6 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24 1916, to Sept 3rd 1916, that I last saw h[illegible] alive on Sept 3rd 1916, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Dysentery

(Duration) ..... Yrs. ..... mos. 1 3 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Broom M. D.
9-4 1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Sep 5 1916

20. UNDERTAKER: Fry & Summers Co. — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

13

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

#223

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise'

Registration District No. 2

Primary Registration District No. 1004

(No. 412 State St.)

File No. 15397

Registered No. 303

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Irene Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 27 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Boise Idaho.

10. NAME OF FATHER: Lee V Smith

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Mary A Carriger

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lee V. Smith

(Address) Meridian Idaho R Three #2

15.

Filed 8/9 1916

E. G. Cotton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1916, to Aug 29 1916, that I last saw her alive on Aug. 28 1916, and that death occured on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:

Too Low Vitality. Premature birth

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. Allen Cameron M. D.

8-29 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery — DATE OF BURIAL: Aug 30 1916

20. UNDERTAKER: Tate & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

2

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2 202
Primary Registration District No. 1004
File No. 15398
Registered No. 202

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 412 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Smith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (write the word.): Single

6. DATE OF BIRTH. Aug (Month) 27 (Day) 1916 (Year)

7. AGE ....Yrs. ....Mos. 1 ds. | IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho.

10. NAME OF FATHER: Lee V Smith

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Mary A Parrenger

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lee V. Smith.
(Address) Meridian Ida R. Rt No 2

15. Filed 8/29 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 - 1916, to Aug 27 1916, that I last saw her alive on Aug 27 1916, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Too Low Vitality -
Premature - birth
(Duration) ....Yrs. ....mos. 1/4 ds.
Contributory (Secondary)
(Duration ....yrs. ....mos. ....ds.
(Signed) M. Allen Callaway M. D.
8-27 1916 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Valley Creek Cemetery | DATE OF BURIAL: Aug 30 1916

20. UNDERTAKER: Frye Summers | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2 — 201
Primary Registration District No. 1004
File No. 15399
Registered No. 201

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pauline Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 27 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 4 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho.

10. NAME OF FATHER: Lee V. Smith

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Mary A. Carrigan

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lee V. Smith
(Address) R. F. D. #2 Meridian Idaho

15. Filed 8/29 6 — E. J. Carter, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-27- 1916, to 8-28- 1916, that I last saw h[illegible] alive on 8-28- 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Im Low Vitality - Premature Birth

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. Allen Greenway M. D.
8-28 1916 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Creek Cemetery — DATE OF BURIAL: Aug 30 1916

20. UNDERTAKER: Gray & Summers — ADDRESS: Boise Idaho.

BYNS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5- ... A. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 15401

County of Ada

City of Boise (No. 410 State St.)

Registered No. 185

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Gabiola

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 9th (Day) 1916 (Year)

7. AGE ... Yrs. ... Mos. ... ds. IF LESS than 1 day how many ... hrs. or 10 min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Ada Co. Idaho

10. NAME OF FATHER: Manuel Gabiola

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Dolores Aspiri

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev B. Arague

(Address) Boise, Idaho

15. Filed 8/10 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 9th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 191..., to ... 191..., that I last saw h... alive on ... 191..., and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Stillborn

Premature - 5 lbs.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) T. O. Calluet M. D.

19... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 8/10 1916

20. UNDERTAKER: Schreiber & Hodgson — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 15402

Registered No. 187

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Long

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 20 (Day) 1916 (Year)

7. AGE ....Yrs....Mos....ds. IF LESS than 1 day how many 0 hrs. or 5 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Boise

10. NAME OF FATHER James Long

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Grace Gelipei

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) [illegible]
(Address) [illegible]

15. Filed 8/21 1916

[illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. (Month) 20th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20th 1916, to ——— 191..., that I last saw h.l.m. alive on Aug 20th 1916, and that death occured on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:
Premature 6 1/2 months foetus
Only breathed a few times.
Removed by Caesarean Section.

(Duration) ....Yrs....mos....ds.

Contributory (Secondary) ....

(Duration ....yrs....mos....ds.

(Signed) L. P. McCall M. D.

19.... (Address) Boise Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: Aug 22 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 15403

Registered No. 228

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 112 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chin Mau Sui

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) (Year): 1848

7. AGE: 68 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: not obtainable

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas Y Encow
(Address)

15. Filed 9/30 1916

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Sept. (Day) 28 (Year) 1916

17. I HEREBY CERTIFY, That I attended deceased from Sept. 24 1916, to Sept. 28 1916, that I last saw h. (was) alive on Sept. 27 1916, and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Bright Disease
(Nephritis)
(Duration) 4 years Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Alex Bonte M. D.
9-29 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Chinese Cemetery — DATE OF BURIAL: 10/2 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15404

Registered No. 230

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Abstarczyk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. (Month) (Day) (Year): 1868

7. AGE: 48 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jack Abstarczyk
(Address) Nampa, Ida.

15. Filed 9/30 1916

E. Keeton
Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 29th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1916, to Sept 29 1916, that I last saw her alive on Sept 29 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Peritonitis following Strangulated Hernia, fundal

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Jos. R. Numbers M. D.
9/30 1916. (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Nampa, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho — DATE OF BURIAL: 19 1916

20. UNDERTAKER: Schreiber & Siedenfaden — ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15405

Registered No. 229

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carrie Ryals.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Mar (Month) 16 (Day) 1887 (Year)

7. AGE: 29 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho Falls. Idaho,

10. NAME OF FATHER: Judd Johnson

11. BIRTHPLACE OF FATHER (State or Country): Ohio U. S.

12. MAIDEN NAME OF MOTHER: Martha Parter

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) W B Ryals

15. Filed 9/30 191 6

E A Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26th 191 6 to Sept 28 191 6, that I last saw h alive on Sept 28 191 6, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) Yrs. 2 mos. — ds.

Contributory (Secondary) Hemorrhage

..... (Duration) Yrs. mos. 1 ds.

(Signed) H. Woodfield M. D.

(Address) Emporia Kans.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence So. Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/1 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

Good friend

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

File No. 15406

Registered No. 1546

County of Boise

City of Boise

(No. Ruby Creek St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Ann Hatten

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 13 (Day) 1862 (Year)

7. AGE: 64 Yrs. 4 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: James Reynolds

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. A. Hatten

(Address) Boise City Boise

15. Filed Sept 29 1916

E. P. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1916, to Sept 24 1916, that I last saw her alive on Sept 24 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

9/28 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Ruby Creek Boise Co.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 9/29 1916

20. UNDERTAKER: Schneider & Niedenfuer | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2047
(No. Joplin Locality Ada Co)

File No. 15407
Registered No. 56

1. PLACE OF DEATH.

County of Ada
or Town Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lee Hon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
1/ (Month) (Day) 1844 (Year)

7. AGE
68 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): Gardener

9. BIRTHPLACE
(State or Country) China

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) [illegible]

15.
Filed 9/23 1916
E. H. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1916 to Aug 1 1916, that I last saw h[illegible] alive on Aug 1 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis
Kidneys

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Young C Bong M. D.
19 .... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days
In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ada Co. Cemetery
DATE OF BURIAL: 9/24 1916

20. UNDERTAKER: Schreiber & Lidenfelder
ADDRESS: Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & STNRS. 24652

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15408

Registered No. 64

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City or Town Boise (No. 1½ Miles South of Town St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Rice

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May 7th 1868
(Month) (Day) (Year)

7. AGE: 48 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: J. C. Hefner

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Miss Dillon

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. Gulbrick
(Address) Boise RR 4

15. Filed Sept 15 1916 E. J. Keaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1916 to Sept 14 1916, that I last saw her alive on Sept 14 1916, and that death occured on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Mitral stenosis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Tallman M. D.
9/15 1916 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL 191

20. UNDERTAKER: Schreiber & Anderson — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 15409
Registered No. 53

1. PLACE OF DEATH.
County of Ada
City of Near Boise (No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjiman F. Russell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) (Year): 1841

7. AGE: 75 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. G. Burnett
(Address) Soldiers Home.

15. Filed Sept 15 1916 E. H. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Sept (Day) 14 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1916, to Sept 14 1916, that I last saw him alive on Sept 14 1916, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Allen M. D.
Sept 15 1916. (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept 16 1916

20. UNDERTAKER: Gray & Summers — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOHS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 15410
Registered No. 57

1. PLACE OF DEATH.
County of Ada
City of (or town) Boise (No. Lambertson Ada)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Francis Monlux

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 8 (Day) 1849 (Year)

7. AGE 67 Yrs. 5 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Bernard Monix.

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mas. Mc. Donald

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. W. Monlux
(Address) Boise R. D. #2

15. Filed Sept 11 1916 E. F. Eaton Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9 1916, to ~~1917~~, that I last saw her alive on and died Sept 9 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E Dunmyer Coroner Ada Co.

Sept 9 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/11 1916

20. UNDERTAKER: Schreiber & Sedgwick — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15411

Registered No. 51

1. PLACE OF DEATH.

County of Ada

~~City of~~ near Eagle

(No. Near Eagle Ida St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Floyd William Mathews.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. April (Month) 25 (Day) 1916 (Year)

7. AGE: 0 Yrs. 4 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Star Ida

10. NAME OF FATHER: Elmer Mathews.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Kate Bingman

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wm Engeroth

(Address) Eagle Ida R#1

15. Filed Sept 8th 1916

D. J. Eaton
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1916, to Sept 7 1916, that I last saw him alive on Sept 6 1916, and that death occured on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Cal. Defect

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. F. Pressel M. D.

Sept 8 1916 (Address) Meridian Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: Sept 8 1916

20. UNDERTAKER: Schreiber & Anderson — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15412

Registered No. 50

1. PLACE OF DEATH.

County of Ada.

City of Boise.

(No. Soldiers Home. St.)

Registration District No. 8

Primary Registration District No. 2004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles W. Downs.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed ~~Widower~~

6. DATE OF BIRTH: Nov 19 (Month) 1842 (Year)

7. AGE: 73 Yrs. 10 Mos. 15 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Veteran Civil War

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois.

10. NAME OF FATHER: Wilson Downs.

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Susan Lefever.

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Cora V. Beagle

(Address) .....

15. Filed Sept 5 11 1916

E. J. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1916, to Sept 4 1916, that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cancer of bladder

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo Callista M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Sep 5 1916

20. UNDERTAKER: Fry & Summers Co. — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15414

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Beulah A. Webb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. May (Month) 24 (Day) 1840 (Year)

7. AGE: 76 Yrs. 3 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): (Farmer's)

9. BIRTHPLACE (State or Country): Calaway Co, Kentucky

10. NAME OF FATHER: Louis Allen

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Elizabeth Alexander

13. BIRTHPLACE OF MOTHER (State or Country): South Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W E Harris
(Address) Emmett Ida.

15. Filed 9/20 1916 — J L Reynolds, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: [illegible] (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1916, to Sept 16 1916, that I last saw her alive on Sept 16 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Exophthalmic Goitre

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L N Cummings M. D.

9/20 1916 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 9/20 1916

20. UNDERTAKER: C D Bucknum — ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15415
Registered No. .....

1. PLACE OF DEATH.
County of Gem
City of Emmett
(No. ....., ... St.)
Registration District No. 6
Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hiram L. Wilbur

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb (Month) 2 (Day) 1845 (Year)

7. AGE 71 Yrs. 7 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Joseph Wilbur

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Perry H. Wilbur
(Address) Emmett Ida

15.
Filed 9/30 1916
J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1916, to Sept 27 1916, that I last saw him alive on Sept 27 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Paresis
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) B. O. Black M. D.
19..... (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Emmett Idaho — DATE OF BURIAL 9/29 1916

20. UNDERTAKER C. D. Buckner — ADDRESS Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SPACE RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15416

Registered No. 30

1. PLACE OF DEATH
County of Latah
City of Avon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2147
Primary Registration District No. 67
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Herbert A Kleer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	single

6. DATE OF BIRTH: Aug. (Month) 11 (Day) 1916 (Year)

7. AGE: 0 yrs. 1 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William Kleer

11. BIRTHPLACE OF FATHER (State or Country): Neb

12. MAIDEN NAME OF MOTHER: Maud Hawkins

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 9/21 1916 P. C. Faust Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-16 1916, to ..... 191..., that I last saw him alive on 9-16 191..., and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Acute Bronchitis
.....
.....
(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary) Improper care
(Duration) ... yrs. ... mos. ... ds.
(Signed) P. C. Faust M. D.
9/21 1916 (Address) Dr. Deary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Avon Cemetery — DATE OF BURIAL: 9/18 1916

20. UNDERTAKER: Fred Anderson — ADDRESS: Avon Palouse Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147
Primary Registration District No. 67
File No. 15417
Registered No. 31

1. PLACE OF DEATH
County of Latah
City of Deary
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alma P. Young

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 18 (Day) 1898 (Year)

7. AGE: 18 yrs. 2 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Wm E. Young

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Rachel Nichols

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Davis
(Address) Deary Ida

15. Filed 9/26 1916 P. E. Faust Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-11 1915, to 9-13 1915, that I last saw her alive on 9-13 1915, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 1 yrs. 9 mos. ds.
Contributory (Secondary) typhoid fever
(Duration) yrs. mos. ds.
Pleurisy influenza

(Signed) P. E. Faust M. D.
9/26 1916 (Address) Deary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pine Crest
DATE OF BURIAL: 9-26 1916

20. UNDERTAKER: none
ADDRESS: -

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 1976C

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15418

Registered No. 46

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho

City of Stites

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 106

Primary Registration District No. 2184

(No. ....., ... St.)

2. FULL NAME Warren Henry Butcher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Married

6. DATE OF BIRTH: May (Month) 15 (Day) 1881 (Year)

7. AGE: 35 yrs. 3 mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Buttermaker
(b) General nature of industry business, or dstablishment in which employed (or employer): Creamery

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Samuel S Butcher

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Malinda Houck

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Ada Butcher
(Address): Stites

15. Filed Sept 14 1916 — J M Huberkuoss, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1916 to Sept 13 1916 that I last saw h[illegible] alive on Sept 13 1916 and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Paratyphoid Fever

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Entsminger M. D.

Sept 14 1916 (Address) Stites Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Swamp Pa — DATE OF BURIAL ..... 191...

20. UNDERTAKER: Johnson — ADDRESS Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15419
Registered No. 20

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harlan M. Hoyt

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept 10 1916 (Month) (Day) (Year)

7. AGE: ——yrs. ——mos. 1 ds.
IF LESS than 1 day how many .....hrs. or .....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston Idaho.

10. NAME OF FATHER: Harlan M. Hoyt.

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Margaret Sutter

13. BIRTHPLACE OF MOTHER (State or Country): Lewiston Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. C. Sutter
(Address) 407 Main St. Lewiston Idaho.

15.
Filed Oct. 10 - 1916
L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1916, to Sept 11 1916
that I last saw him alive on Sept 11 1916
and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Uraemic Poisoning.
12 Hours
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): None
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edgar L. White M. D.
Sept 11 1916 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: 9/11 1916

20. UNDERTAKER: [illegible]
ADDRESS: Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15420

Registered No. 16

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie Waldfell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Feb. (Month) 5 (Day) 1862 (Year)
7. AGE: 54 yrs. 7 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Germany
10. NAME OF FATHER: Fred Johnson
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (State or Country): Germany
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Waldfell
(Address) Culdesac
15. Filed Oct 10 1916 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 4 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 1912; to Sept 4 1916
that I last saw her alive on Sept 4 1916
and that death occurred on the date stated above, at 6. P. M.,
The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
(Duration) 3 yrs. mos. ds.
Contributory (Secondary) Rheumatism
(Duration) yrs. mos. ds.
(Signed) John G. Kelly M. D.
Sept 6 1916 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 11 ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? Culdesac
Former or usual residence Culdesac Ida.

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: 9/7 1916
20. UNDERTAKER: J. Vasa
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15421
Registered No. 17

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
Registration District No. 9
Primary Registration District No. 1809
(No. St. Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isadell Goldman
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 3 (Day) 1877 (Year)

7. AGE: 39 yrs. 4 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Philadelphia

10. NAME OF FATHER: Fredrick Kluy

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Margaret Schwongkoff

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. C. Goldman
(Address) Culdesac Idaho

15.
Filed Oct. 10 - 1916
L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 7 (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1916, to Sept 6 1916
that I last saw her alive on Sept. 6 1916
and that death occurred on the date stated above, at 9.30 A. M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) 6 yrs. mos. ds.
Contributory (Secondary): not known
(Duration) yrs. mos. ds.
(Signed) D. S. Adler & Bradbury D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos. 8 ds.
In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence: Culdesac Ida

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: 191

20. UNDERTAKER: J. C. Warren
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15422
Registered No. 18

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1007
(No. St Joseph Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esler Harrison Beale

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Aug (Month) 16 (Day) 1851 (Year)

7. AGE: 65 yrs. 0 mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Orlando Harrison

11. BIRTHPLACE OF FATHER (State or Country): Isle of Man

12. MAIDEN NAME OF MOTHER: Mary Ann Totty

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jno. Kennedy
(Address) Culdesac Idaho

15. Filed Oct 10 - 1916 L Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1916, to Sept 7 1916
that I last saw her alive on Sept 5 1916
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
Liver Incidental
Uremia
(Duration) ..... yrs. 6 mos. ..... ds.
Contributory (Secondary) Acute Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr S Calley & Broadbent M. D.
Sept 7 1916 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence Culdesac Ida.

19. PLACE OF BURIAL OR REMOVAL: Cut de Sac
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Gasser
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15423
Registered No. 19

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1007
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Ray Lester Hagen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 20 (Day) 1908 (Year)

7. AGE: 8 yrs. mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) scholar

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: L. L. Hagen

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Emma M. Stamper

13. BIRTHPLACE OF MOTHER (State or Country): Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. L. Hagen
(Address) Woodland

15. Filed Oct 10 1916 P. G. Parkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1916, to Sept 9 1916, that I last saw h[illegible] alive on Sept 9 1916 and that death occurred on the date stated above, at 3:45 M.

The CAUSE OF DEATH* was as follows:
Septic Peritonitis

..... (Duration) ..... yrs. ..... mos. [illegible] ds.
Contributory (Secondary) Appendicitis
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elmer G Reese M. D.
Sept 10 1916 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodland Ida
DATE OF BURIAL: 10 Oct 1916

20. UNDERTAKER: C. J. Vassar
ADDRESS: Lewiston

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 15424
Registered No. 16

1. PLACE OF DEATH.
County of Elmore
City of Mtn Home Idaho (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pio Jayo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Spanish
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
May (Month) 5 (Day) 1892 (Year)

7. AGE
24 Yrs. 3 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Spain

10. NAME OF FATHER Isidro Jayo

11. BIRTHPLACE OF FATHER (State or Country) Spain

12. MAIDEN NAME OF MOTHER Joaquina Rementeria

13. BIRTHPLACE OF MOTHER (State or Country) Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anatasio Jayo
(Address) Haise Idaho

15.
Filed Sept. 6th 1916 Burkholder Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept. (Month) 4th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 4th 1916, to Sept. 4th 1916, that I last saw him alive on Sept. 4th 1916, and that death occured on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Gun shot wound of head, from gun in hand of one Strickler — held for manslaughter
(Duration) Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C W Mather M. D.
9/4 1916 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home, Idaho — DATE OF BURIAL: 9/6 1916

20. UNDERTAKER: J. M. Cowen — ADDRESS: Mtn Home

SYMS - YORK CO., PTRS. & BORS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 44
Primary Registration District No. 2121
File No. 23 13425
Registered No.

1. PLACE OF DEATH
County of Owyhee
City of Drumeon (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John A Thorne
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Widowed

6. DATE OF BIRTH
Aug 1 1852
(Month) (Day) (Year)

7. AGE
54 yrs. 0 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farming
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) U S.

12. MAIDEN NAME OF MOTHER Don't Know.

13. BIRTHPLACE OF MOTHER (State or Country) U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. O. Thorne
(Address) Drumeon Idaho

15.
Filed Aug 24 1916 J. C. Bartlett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
August 20 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1 1916 to Aug 20 1916 that I last saw him alive on Aug. 20 1916 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular heart disease of the Mitral valve
(Duration) 10 yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Bartlett M. D.
Aug 24 1916 (Address) Drumeon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Drumeon | DATE OF BURIAL Aug 21 1916

20. UNDERTAKER J E Sears. | ADDRESS Drumeon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Owyhee
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 44
Primary Registration District No. 2121

File No. 24
Registered No. 15426
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 24 (Day) 1910 (Year)

7. AGE: 6 yrs. 4 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Henry W. Gahan

11. BIRTHPLACE OF FATHER (State or Country): Kans. U.S.

12. MAIDEN NAME OF MOTHER: Nellie Wisner

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. L. Wisner
(Address): Bruneau

15. Filed 10/2 1916 J C Bartlett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1916, to 9/30 1916, that I last saw h[im] alive on Sept 30 1916 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Accident
Runover by wagon
(Duration) yrs. mos. ds.
Contributory (Secondary) Hemorrhage
(Duration) yrs. mos. ds.

(Signed) J C Bartlett M. D.
10/2 1916 (Address) Bruneau

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bruneau
DATE OF BURIAL: 10/1 1916

20. UNDERTAKER: J E Sears
ADDRESS: Bruneau

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 44
Primary Registration District No. 2121
File No. 22
Registered No. 15427

1. PLACE OF DEATH
County of Cowyhee
City of Drumheau (No. ..., St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sherman Brunsen Ives

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed
6. DATE OF BIRTH: Dec. 13 1828 (Month) (Day) (Year)
7. AGE: 87 yrs. 7 mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): New York
10. NAME OF FATHER: Don't Know
11. BIRTHPLACE OF FATHER (State or Country): United States
12. MAIDEN NAME OF MOTHER: Don't Know
13. BIRTHPLACE OF MOTHER (State or Country): Don't Know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank C Ives
(Address) Sumpter Oregon
15. Filed Aug 19 1916 J. C. Bartlett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. (Month) 19 th (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug. 16 1916, to Aug 19 1916, that I last saw h.im. alive on Aug 19 1916 and that death occurred on the date stated above, at 11 A. M.
The CAUSE OF DEATH* was as follows: Accident, Fracture of Left Lower Jaw and the Occipital bone
(Duration) — yrs. — mos. 3 ds.
Contributory (Secondary) Concussion of Brain
(Duration) ... yrs. ... mos. ... ds.
(Signed) J. C. Bartlett M. D.
8/19 1916 (Address) Brunneau

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Brunneau Idaho — DATE OF BURIAL: Aug 20 1916
20. UNDERTAKER: J. M Cowen — ADDRESS: Mt Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Minidoka — Registration District No. 19

City of Rupert — Primary Registration District No. 2013 — File No. 15428

(No. ....., ... St.) — Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank O Warner

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH — Feb (Month) 14 (Day) 1862 (Year)

7. AGE — 54 yrs. 7 mos. 13 ds. — IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Labor
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Unit Unw

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alv Zimmerman
(Address) Caldwell Idaho

15.
Filed 9-29 1916 — E H Clemens, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH — Sept. (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 25 1916, to Sept. 28 1916, that I last saw h...alive on Sept. 28. 1916, and that death occurred on the date stated above, at 29 M.

The CAUSE OF DEATH* was as follows:
Uremia from
Nephritis

(Duration) ..... yrs. ? mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Kenagy M. D.
1916 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Caldwell Ida — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: W A Goodman — ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15429
Registered No.

1. PLACE OF DEATH. Registration District No. 47
County of Lewis Primary Registration District No. 2124
City of Nezperce No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Andrew Sorenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Dec (Month) 5 (Day) 1844 (Year)
7. AGE: 62 yrs. 9 mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Plumber
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Denmark
10. NAME OF FATHER: Jorge Sorenson
11. BIRTHPLACE OF FATHER (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Elizabeth Gregory
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Heaney
(Address) Nezperce, Idaho.
15.
Filed 7-30 1916 J. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 9-27 (Month) (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct-31 1915, to Sept 27 1916
that I last saw him alive on 9-27 1916
and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

..... (Duration) ..... yrs. 11 mos. 4 ds.
Contributory (Secondary) Myelitis
..... (Duration) ..... yrs. ..... mos. 3 ds.
(Signed) E. Taylor M. D.
9-29 1916 (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nezperce, Idaho — DATE OF BURIAL: 9-30 1916
20. UNDERTAKER: D. P. Donovan — ADDRESS: Nezperce Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2150
(No. ....., ... St.)

File No. 15430
Registered No. 64

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph adolph Vick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ? (Month) ? (Day) 1855 (Year)

7. AGE: 61 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stock Raising
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Joseph Vick

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Mary Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J Billman
(Address) Idaho Falls, Ida

15. Filed Oct 9 1916
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1915, to Sept 6, 1916, that I last saw h— alive on Sept 1, 1916, and that death occured on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Cancer of Jaw
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) S. S. Fuller M. D.
Oct 9 1916 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Acon, Idaho — DATE OF BURIAL: 10/8 1916

20. UNDERTAKER: C C Dinwoodey — ADDRESS: Idaho Falls

Dr Fuller

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15431

Registered No. 27

1. PLACE OF DEATH.

County of Bonneville

City of Ida Falls

Registration District No. 73

Primary Registration District No. 2170

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles E Smith Sellars

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. January (Month) 29 (Day) 1885 (Year)

7. AGE: 31 Yrs. 8 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Stock Raising

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iona, Idaho

10. NAME OF FATHER: James A Smith

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Annie Sellers

13. BIRTHPLACE OF MOTHER (State or Country): Miss.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James A Smith

(Address) Iona Ida

15. Filed Oct 9 1916 Casey Emmond Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 191..., to Oct 6 1916, that I last saw h.m alive on Oct 6 1916, and that death occured on the date stated above, at 3:30 M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Larynx and tongue

(Duration) 10 Yrs. 8 mos. ——— ds.

Contributory (Secondary) Chronic Synovitis Knee (Duration) 3 yrs. 9 mos. 3 ds.

(Signed) J W Brandstetter M. D.

19.... (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iona Ida — DATE OF BURIAL: 10/8 1916

20. UNDERTAKER: C E Dunwoody — ADDRESS: Ida Falls

BYRON - YORK CO., PTRS. & BKBS. 24658

Dr Pendleton

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15432

Registered No. 67

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

(No. ....., ... St.)

Registration District No. 23

Primary Registration District No. 2112

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Masao Buto

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Aug (Month) 18 (Day) 1916 (Year)

7. AGE: 0 Yrs. 1 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iona, Idoho.

10. NAME OF FATHER Masataro Buto

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER Tai.

13. BIRTHPLACE OF MOTHER (State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C E Dunwoody (with)

(Address) Idaho Falls Idaho

15. Filed Oct. 6 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-30 1916, to 9-30-1916, that I last saw h..... alive on 9-30-1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Child was dying when brought to office. Could not determine specific cause of death.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Hollister M. D.

19..... (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: Oct 1 1916

20. UNDERTAKER: C E Dunwoody — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2180
File No. 15433
Registered No. 29

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Wm Carter

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 27 (Day) 1877 (Year)

7. AGE: 39 Yrs. 0 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Hugh Carter

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Laura Willson

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A.R. Carter
(Address) Idaho Falls

15. Filed Oct 1 1916 Eng Raymond, Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1916, to Sept 10 1916, that I last saw h— alive on Sept 6 1916, and that death occured on the date stated above, at 9 9 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. C. Hollister, M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: 9/11 1916

20. UNDERTAKER: C.C. Dunwoody — ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15434

Registered No. 54

1. PLACE OF DEATH.

County of Bonneville

City of Ida Falls

Registration District No. 73

Primary Registration District No. 2105

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph a Coles

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 30 (Day) 1900 ~~1899~~ (Year)

7. AGE: 15 Yrs. 11 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Milo, Idaho

10. NAME OF FATHER: Alvin Coles

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Fogg

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C C Dunwoody by phone
(Address) .....

15. Filed Oct 1 1916 Compared
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1916, to Sept 15 1916, that I last saw h..... alive on ..... 191.., and that death occured on the date stated above, at 12:05 P.M.

The CAUSE OF DEATH* was as follows:
Gun shot wound of leg. Accidental
(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. G. Anderson M. D.
19..... (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Milo, Ida — DATE OF BURIAL: Sept 10 1916

20. UNDERTAKER: C C Dunwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
(No. ..... St.)

File No. 15435
Registered No. 73

1. PLACE OF DEATH.
County of Bonneville
City of Iona
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rhea Steele

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug. 28 (Month) (Day) 1914 (Year)

7. AGE: 2 Yrs. ..... Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iona Idaho

10. NAME OF FATHER: John Steele

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Myrtle Eldredge

13. BIRTHPLACE OF MOTHER (State or Country): Ogden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lorenz Waldram.
(Address) Idaho Falls

15. Filed Sept 28 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 25 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25 1916, to ..... 191..., that I last saw h[illegible] alive on ..... 191..., and that death occured on the date stated above, at 1230 P.M.

The CAUSE OF DEATH* was as follows:
Accidental
Drowning
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Frank N Dillon M. D.
9/28 1916 (Address) Blandinsville Ill.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Iona Idaho — DATE OF BURIAL: Sept 27 1916

20. UNDERTAKER: G. F. Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181
(No. ....., ... St.)

File No. 15436
Registered No. 31
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Jesse C Hookersmith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Oct (Month) 6 (Day) 1894 (Year)
7. AGE: 21 yrs. 4 mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farm
(b) General nature of industry business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Washington
10. NAME OF FATHER: James W Hookersmith
11. BIRTHPLACE OF FATHER (State or Country): Oregon
12. MAIDEN NAME OF MOTHER: Reid
13. BIRTHPLACE OF MOTHER (State or Country): Kansas
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James W Hookersmith
(Address) Rich Creek
15. Filed Oct 5 1916 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 22 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1916, to Sept 22 1916, that I last saw him alive on Sept 22 1916 and that death occurred on the date stated above, at 9:40 P.M.
The CAUSE OF DEATH* was as follows:
Complete rupture of right cerebrum. Fractured skull
Accidental fall, yrs. mos. 3 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Dr Stanley F Orr M. D.
Sept 23 1916 (Address) Cottonwood

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grangeville — DATE OF BURIAL: Sept 24 1916
20. UNDERTAKER: A H Barr — ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Denver
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2761
(No. ....., ... St.)

File No. 15437
Registered No. 30
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rachel Lyttle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (*Write* the word.)

6. DATE OF BIRTH: Sept 24 1839 (Month) (Day) (Year)

7. AGE: 77 yrs. 11 mos. 26 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Int Denver Indiana

10. NAME OF FATHER: John J Hill

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Amy Moore

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Rood
(Address) Denver, Idaho

15.
Filed Oct 5 1916 G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 20 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916, to Sept 20 1916, that I last saw her alive on Sept 1 1916, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Senile Debility

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.
9/21 1916 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Denver Idaho
DATE OF BURIAL: Sept 22 1916

20. UNDERTAKER: E S Hancock
ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 1001
(No. ....., ... St.)

File No. 15438
Registered No. 29
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James H Irwin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): widower

6. DATE OF BIRTH: may (Month) 1st (Day) 1849 (Year)

7. AGE: 67 yrs. 3 mos. 15 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cumberland Ohio

10. NAME OF FATHER: William Irwin

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Elisebeth Dilleay

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W C Irwin
(Address) Grangeville Ida

15.
Filed Oct 5 1916 G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1916, to Sept 15 1916, that I last saw h[e] alive on Sept 14 1916 and that death occurred on the date stated above, at 8:30 A. M.

The CAUSE OF DEATH* was as follows:
Bulber Paralysis

(Duration) unknown yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) G S Stockton M. D.
9/16 1916 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View
DATE OF BURIAL: Sept 16 1916

20. UNDERTAKER: E S Hancock
ADDRESS: Grangeville

SYMS - YORK CO., PTRS. & BDRS. 1976O

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. 2006
(No. ____, ____ St.)

File No. 15440
Registered No. ____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ewald A Werner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. May (Month) 18 (Day) 1880 (Year)

7. AGE: 36 Yrs. 3 Mos. 27 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Aug F. Werner

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Charlotte Warner

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) B W Werner
(Address) R D - Nampa Ida

15. Filed Sept 19 1916 Orsa D Caldwell Local Registrar
Anna Patrick Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1916, to Sept 15 1916, that I last saw h~~im~~ alive on 9-12 1916 and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Brain tumor
(Duration) Yrs. 6 mos. ____ ds.
Contributory (Secondary) ____
(Duration ____ yrs. ____ mos. ____ ds.

(Signed) W. H. Tallman M. D.
9/15 1916 (Address) Bond & Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs ____ mos ____ days. In the State ____ yrs ____ mos ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem
DATE OF BURIAL: 9-19 1916

20. UNDERTAKER: Floyd Robinson
ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ..... St.)

File No. 15441
Registered No. .....

1. PLACE OF DEATH.

County of Canyon
City of Nampa

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Antone Hinkey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. (Month) — (Day) — (Year) 1855

7. AGE: 61 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hotel Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: John Hinkey

11. BIRTHPLACE OF FATHER (State or Country): Do not know

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. H. Emmett
(Address) Nampa Ida

15. Filed Sept 24 1916 Dist. Clerk
Local Registrar
By Frances Fairfield Deputy.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 9 1916, to Sep 18 1916, that I last saw him alive on Sep 18 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Paresis)
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Arterio sclerosis
(Duration 10 yrs. ..... mos. ..... ds.

(Signed) H. P. Ross M. D.
Sept 24 1916 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerman Cemetery	9-24 1916
20. UNDERTAKER	**ADDRESS**
Fred E. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., DENVER

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 1006

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15442

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Nampa (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel James Jennings

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 20 (Day) 1848 (Year)

7. AGE: 68 Yrs. ..... Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Minister

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: J. J. Jennings

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Margarite Bake

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. J. Jennings

(Address) 324 Ye So Ave Nampa Ida

15.

Filed Sept 21, 1916 W. D. Calonge Local Registrar

By [illegible] Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1916, to Sept 16 1916, that I last saw him alive on Sept 16 1916, and that death occured on the date stated above, at 3.20 P. M.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(Duration) ? Yrs. ..... mos. ..... ds.

Contributory (Secondary): Chronic Bright's Disease

(Duration ? yrs. ..... mos. ..... ds.

(Signed) Clyde E. Watson M. D.

Sept 22 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn	9/21/1916
20. UNDERTAKER	**ADDRESS**
H. Robinson	Nampa Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. 1006
File No. 15443
Registered No. ____

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joe Silva

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1888 (Year)

7. AGE: 28 Yrs. ____ Mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep Herder
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE
(State or Country) Portugal

10. NAME OF FATHER: Do not Know

11. BIRTHPLACE OF FATHER
(State or Country) " " "

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER
(State or Country) " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Asordo
(Address) Nampa Ida

15. Filed Sept 18 1916 Dick D Calonge Local Registrar
Emma Lackey Deputy.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1916, to Sept 15 1916, that I last saw him alive on Sept 15 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever with Pneumonia

(Duration) ____ Yrs. ____ mos. 15 ds.

Contributory (Secondary) ____
(Duration ____ yrs. ____ mos. ____ ds.

(Signed) J. H. Murray M. D.
9-16 1916 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Catholic Cem — DATE OF BURIAL: 9-18 1916

20. UNDERTAKER: Fred Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., 1915 & 1916

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15444

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. Nampa Gen'l Hospital St.)

2. FULL NAME Esther Hamilton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Do not know (Month) (Day) 1908 (Year)

7. AGE: 8 Yrs. ..... Mos. - ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER A H Hamilton

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Alice Garoutch

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) Caldwell Idaho

15. Filed Sept 15 1916 D. D. Calonge Local Registrar

[illegible] Deputy

SYMS - YORK CO., PTRS. & BOOK MFRS.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Acute tuberculer pneumonitis

(Duration) 0 Yrs. 0 mos. 1½ ds.

Contributory (Secondary) Pulmonary tuberculosis

(Duration unknown yrs. mos. ds.

(Signed) Geo. A. Allen M. D.

19..... (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wolverton Penn. DATE OF BURIAL: 9-15 1916

20. UNDERTAKER: Fred Robinson ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 1006
File No. 15445
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME L. B. Douglass

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 8 (Day) 1859 (Year)

7. AGE: 57 Yrs. 8 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER Barney Douglass

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Frazier

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Eva M Douglass
(Address) Nampa Idaho

15. Filed Sept 30 1916. Anna Hatfield Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6th 1916, to Sept 27 1916, that I last saw h[illegible] alive on Sept 27 1916, and that death occured on the date stated above, at 7 a. M.
The CAUSE OF DEATH* was as follows:

Pyloric Stenosis

(Duration) ..... Yrs. ..... mos. 21 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J H Murray M. D.
9-27 1916 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cholerlawn Cem — DATE OF BURIAL: 9-30 1916
20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 4

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. 1006
File No. 15446
Registered No. ____

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Johnnie L. Books

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. June (Month) 11 (Day) 1897 (Year)

7. AGE 19 Yrs. 3 Mos. 17 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Maryland

10. NAME OF FATHER Chas Books

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Lizzie Zerinska

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lizzie Books
(Address) Tacoma Wash

15. Filed Sept 30 1916 Anna Hatfield Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22 1916, to Sept 25 1916, that I last saw him alive on Sept 25 1916, and that death occured on the date stated above, at 5.30 A M.
The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ____ Yrs. ____ mos. 14 ds.
Contributory (Secondary) Pneumonia
(Duration ____ yrs. ____ mos. 4 ds.
(Signed) Clyde Watson M. D.
Sept 25 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 4 days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?....
Former or usual residence Ontario Ore.

19. PLACE OF BURIAL OR REMOVAL Tacoma Wash. | DATE OF BURIAL ____ 191____

20. UNDERTAKER Fred K Robinson | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 15447
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Had none

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 5 (Day) 1916 (Year)

7. AGE: ....Yrs. 1 Mos. 26 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER L. Lovejoy

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Minnie Lavan

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lester Lovejoy
(Address) Nampa Ida

15. Filed Sept 30 1916 Anna Hatfield Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1916, to Sept 30 1916, that I last saw him alive on Sept 30 1916 and that death occured on the date stated above, at 3 a, M.

The CAUSE OF DEATH* was as follows:

Whooping cough

.....(Duration) ..... Yrs. ..... mos. 13 ds.
Contributory (Secondary) Poorly nourished
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J H Murray M. D.
9-30 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Parkerlawn — DATE OF BURIAL 9-30 1916

20. UNDERTAKER Robinson — ADDRESS Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2136
(No. ....., ... St.)

File No. 15449
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Edna Jensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	married

6. DATE OF BIRTH ——— 1
(Month) (Day) (Year)

7. AGE 49 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lucerne Iowa

10. NAME OF FATHER Jessie Sharpe

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Nancy Blackburn

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Lynn M.D
(Address) Montpelier Ida

15.
Filed 9/27/ 1916 W. W. Rees Asst
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Sept 26 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 1 1915, to sept 26 1916, that I last saw her alive on sept 25 1916 and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Uraemia
.....
.....
(Duration) 3 yrs. ——— mos. ——— ds.
Contributory Intoxication
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Lynn M. D.
9/27 1916 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Montpelier Idaho	9/27/ 1916

20. UNDERTAKER	ADDRESS
F. Barbour	Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 82
Primary Registration District No. 2136
File No. 15450
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Rasmussen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Man
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov 29" (Month) (Day) 1873 (Year)

7. AGE: 43 yrs. 10 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bloomington Ida.

10. NAME OF FATHER: N. P. Rasmussen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Dont Known

13. BIRTHPLACE OF MOTHER (State or Country): Danmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Thomas C. Jensen
(Address): Montpelier

15. Filed 9/29/1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 28 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

9/29 1916 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Montpelier Idaho
DATE OF BURIAL: Sept 29 1916
UNDERTAKER: F. Garbach
ADDRESS: Montpelier

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boise
City of Vanwyck
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15
Primary Registration District No. .....

File No. 2315452
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mary Ellen Greene

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 2 (Day) 1860 (Year)

7. AGE: 56 yrs. ..... mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Housekeeping
(b) General nature of industry business, or establishment in which employed (or employer): Ill

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Jno Thomas

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: — Gleason

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G E Boggle
(Address) Cascade Ida

15.
Filed 10-9 1916 Ruth McDonald Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-3 1916, to 10-8 1916, that I last saw h alive on 10-3 1916, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Uremic Poison

(Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) don't know
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G E Boggle M. D.
19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bowlee
DATE OF BURIAL: 10-5 1916

20. UNDERTAKER: .....
ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

County of Gooding — Primary Registration District No. ____ — File No. 15453

City of ____ (No. ____, ____ St.) — Registered No. ____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Hooper

If death occurred in hospital or institution or camp give name instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: November (Month) 23 (Day) 1840 (Year)

7. AGE: Seventy five yrs. eight mos. nine ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Stock raiser & rancher
(b) General nature of industry business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Cornwall, England

10. NAME OF FATHER: James Hooper

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: ____

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs James Hooper
(Address) Bay Lemhi Co Idaho

15.
Filed Aug 9 1916 — E. D. Williams, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug - 1 1916, to Aug 2 1916, that I last saw him alive on Aug 2 1916, and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Valvular Insufficiency ____ (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) Ques Expectans (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. Hillman M. D.
19 (Address) Goldburg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Bay Idaho — DATE OF BURIAL: Aug 4 1916

20. UNDERTAKER: Family — ADDRESS: Bay Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15454

Registered No.

1. PLACE OF DEATH.
County of Custer
City of Challis
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Silvester E Shaw

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 19 (Day) 1846 (Year)

7. AGE: 70 yrs. 6 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mechanic
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Robert Shaw

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Frances Rodhelomy

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Rosala Shaw
(Address) Challis Ida

15.
Filed Aug 16 1916 R D Williams Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1916, to Aug 14 1916, that I last saw h[illegible] alive on Aug 13 1916, and that death occurred on the date stated above, at 2 P.M.*

The CAUSE OF DEATH* was as follows:

Myocarditis,

(Duration) yrs. mos. ds.

Contributory (Secondary) Bright's disease

(Duration) yrs. mos. ds.

(Signed) C L Buttry M. D.

19 (Address) Challis, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Challis — DATE OF BURIAL: 8/16 1916

20. UNDERTAKER: R D Williams — ADDRESS: Challis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PRTS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15455
Registered No. .....

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

1. PLACE OF DEATH.
County of Lemi
City of Mayo
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lodia Cecil Lock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. August (Month) 1 (Day) 1914 (Year)

7. AGE: 2 Yrs. 1 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Union Oregon

10. NAME OF FATHER P D Lock

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Ruth Thornton

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P D Lock
(Address) Mayo Idaho

15. Filed ..... 191.....
R D Williams
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28 1916, to Aug 31 1916, that [redacted] alive on Aug 30 1916, and that death occured on the [redacted] stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:

Diarrhea and Enteritis

(Duration) Yrs. mos. 7 ds.
Contributory (Secondary) acute Gastritis
(Duration) yrs. mos. 5 ds.
(Signed) [signature] M. D.
19..... (Address) Mayo

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: May Idaho — DATE OF BURIAL: .....191.....

20. UNDERTAKER: Family — ADDRESS:

BEGIN RESERVED FOR BINDING
WITH UNFADING INK—THIS IS A PERMANENT RECORD.
...ation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
N. B.

SYMS - YORK CO., PTRS. & BDRS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Custer
City of C Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. St.)

File No. 15456
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Curtis Estes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M	wh	

6. DATE OF BIRTH
Not Known 1
(Month) (Day) (Year)

7. AGE
.....yrs. .....mos. .....ds.
IF LESS than 1 day how many .....*hrs.* or .....*mins.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work County Pauper Miner
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) not known

12. MAIDEN NAME OF MOTHER not Known

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. L. Kerlee
(Address) C Challis Ida

15. Filed Sept 2 26 1916 K D Williams Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Sept 1 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1916, to Sept 1 1916, that I last saw him alive on Sept 1 1916, and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) do not Known ds.

Contributory (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) C. L. Kerlee M. D.
9/1 1916 (Address) C Challis Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Challis Ida | DATE OF BURIAL: 1916

20. UNDERTAKER: K D Williams | ADDRESS: Challis, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SONS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2700
File No. 15457
Registered No. 22

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. On Mullan Road St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Harry Manning

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. (Month) (Day) 1 (Year)
7. AGE: 47 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: merchant
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Surden
10. NAME OF FATHER: Eric Manning
11. BIRTHPLACE OF FATHER (State or Country): Surden
12. MAIDEN NAME OF MOTHER: Johanna Larange
13. BIRTHPLACE OF MOTHER (State or Country): Surden
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hilda Manning
(Address) Mullan, Idaho
15. Filed 9/7 1916 H C Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 4 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 191 , to 191 , that I last saw him alive on Sept 4 1916 and that death occured on the date stated above, at 11:30 P.M.
The CAUSE OF DEATH* was as follows:
Crushed by overturning auto
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Chas. R. Mowry Coroner M. D.
9-5-1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs..mos..days. In the State..yrs..mos..days
Where was disease contracted if not at place of death?
Former or usual residence Mullan Ida

19. PLACE OF BURIAL OR REMOVAL: Mullan — DATE OF BURIAL: 1916
20. UNDERTAKER: Hand Mfg Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 127
Primary Registration District No. 2250
File No. 15458
Registered No. 23

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. On Summit Road (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Bennett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 68 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Bennett

11. BIRTHPLACE OF FATHER (State or Country): [illegible]

12. MAIDEN NAME OF MOTHER: Eliza Whitney

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Frank Brown
(Address): Hillsboro Oregon.

15. Filed 9/16 1916 W. S. Mowery Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 7 P. M.
The CAUSE OF DEATH was as follows:*
Fracture skull & dislocation cervical vertebra
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. R. Mowery Coroner M. D.
9/18 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence Hillsboro Ore.

19. PLACE OF BURIAL OR REMOVAL: Hillsboro Ore. DATE OF BURIAL ..... 191...

20. UNDERTAKER: Hand Mtg Co. ADDRESS: Wallace 2da

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17 15459

1. PLACE OF DEATH. Registration District No. 105
County of [redacted] Primary Registration District No. 2183
City of Cottonwood (No. ..., Unnamed St.) Registered No. .....
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Infant Bledsoe [redacted]
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Sept (Month) 25 (Day) 1916 (Year)
7. AGE: ..... yrs. ..... mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, professsion, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: J M Bledsoe
11. BIRTHPLACE OF FATHER (State or Country): North Carlina
12. MAIDEN NAME OF MOTHER: Ida Williams
13. BIRTHPLACE OF MOTHER (State or Country): North Carlina
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J M Bledsoe
(Address) Cottonwood Ida
15.
Filed Sept 29 1916 H Bonner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 28th (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept. 27 1916, to Sept. 28 1916, that I last saw her alive on Sept 28 1916, and that death occurred on the date stated above, at 3 P M.
The CAUSE OF DEATH* was as follows:
Atelectasis
(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Barnes M. D.
Sept. 29th 1916 (Address) Cottonwood, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood
DATE OF BURIAL: Sept 29 1916
20. UNDERTAKER: A A Nau
ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15461
Registered No. 16

1. PLACE OF DEATH.
County of Cassia
City of Oakley
(No. ..... St.)
Registration District No. 120
Primary Registration District No. 2199
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Claire Viola Haight

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: June (Month) 30 (Day) 1900 (Year)

7. AGE: 16 yrs. 1 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Hector C Haight

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Clara Zuttle

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Clara Haight
(Address) Oakley, Idaho R.

15.
Filed 10-4 1916 E P Wheeler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1916, to Sept 18 1916, that I last saw her alive on Sept 18 1916, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Probable Mitral Stenosis
and Myocarditis Endocarditis
(Duration) 10 yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. H. Nelson M. D.
10/4 1916 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho | DATE OF BURIAL: 9-19 1916

20. UNDERTAKER: A D Thurber | ADDRESS: Oakley Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 120

Primary Registration District No. 2199

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15462

Registered No. 179

1. PLACE OF DEATH.

County of Cassia

City of Oakley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank C Baker Sr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. 21 (Month) (Day) 1845 (Year)

7. AGE: 70 Yrs. 10 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Paul Baker

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Augusta Nanneister

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ray Bedke (Son)
(Address) Oakley Idaho

15.
Filed 10-4 1916
E P Oleman
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 27 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 10 1916, to Sept. 27 1916, that I last saw him alive on Sept. 25 1916, and that death occured on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:
Arterio-Sclerosis.
Emphysema
Acute Cardiac Dilatation
Right Heart
(Duration) Yrs. mos. 17 ds.
Contributory (Secondary) 4 years
(Duration yrs. mos. ds.

(Signed) E P Oleman M. D.
9-27-1916 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Basin Idaho
DATE OF BURIAL: 9-28 1916

20. UNDERTAKER: A. Sagers.
ADDRESS: Oakley.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15463
Registered No. 26

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls

Registration District No. 36
Primary Registration District No.
(No. Twin Falls Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Baby Evans

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: September (Month) 2 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Samuel M. Evans

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Rosa M. Hawkins

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. S.M. Evans
(Address) Hansen Idaho

15.
Filed Sept 17 1916 J.N. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: September (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 2 1916, to Sept 17 1916
that I last saw her alive on Sept 16 1916
and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Marasmus

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Prematurity
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J.N. Davis M. D.
Sept 17 1916 (Address) Kimberly, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 16 ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?.....
~~Former or~~ usual residence Hansen Idaho

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: Sept 17 1916

20. UNDERTAKER: Groseclose & Evans
ADDRESS: Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ..... St.)

File No. 15464
Registered No. 68

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie Helen Magee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. September 27th 1905
~~October 27th 1905~~
(Month) (Day) (Year)

7. AGE: 11 Yrs. —— Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James L. Magee

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Nannie Cole

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James L. Magee
(Address) Caldwell Idaho

15.
Filed Oct. 10 — 1916
John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
~~Oct~~ 10th (Month) 8 — (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 — 1916, to Oct 8 1916,
that I last saw her alive on Oct 8 1916,
and that death occured on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows:

Appendicitis Acute

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. L. Miller M. D.
10-9-1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 10-10 1916

20. UNDERTAKER: W. C. Dyer — ADDRESS: Caldwell.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 7005
File No. 15465
Registered No. 67

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis E. Littlefield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. Sept (Month) 22 (Day) 1832 (Year)

7. AGE: 84 Yrs. — Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Mr. Mack.

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Stata Orsil.

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. E. Littlefield
(Address) Caldwell, Idaho

15.
Filed 10-9- 1916
John V. Meyer
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 1916, to Oct 6 1916, that I last saw her alive on Oct 6 1916, and that death occured on the date stated above, at 5-20 P.M.

The CAUSE OF DEATH* was as follows:
Arterial Sclerosis
Heart Block Primary

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. D. Forney M. D.
10/7 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: Oct 9 1916

20. UNDERTAKER: Beckham Car Co. ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15466

Registered No. 66

Registration District No. 3

Primary Registration District No. 2005

1. PLACE OF DEATH.

County of Canyon

City of Greenleaf

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Valentine Hibbs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower.

6. DATE OF BIRTH. Oct (Month) 17 (Day) 1827 (Year)

7. AGE: 88 Yrs. 11 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: William C. Hibbs

11. BIRTHPLACE OF FATHER (State or Country): Virginia.

12. MAIDEN NAME OF MOTHER: Sarah Hallett

13. BIRTHPLACE OF MOTHER (State or Country): Don't know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. F. Hibbs
(Address) Greenleaf Ida

15.
Filed 10-4- 1916
John S. Meyer
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1916, to Oct 4 1916, that I last saw ~~him~~ alive on Oct 1 1916, and that death occured on the date stated above, at 2P. M.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Brain

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Muller M. D.

10-4-1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parlem Ida — DATE OF BURIAL 1916

20. UNDERTAKER: Peckham & Co — ADDRESS Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15467

Registered No. 65

1. PLACE OF DEATH.

County of Canyon

City of Caldwell,

Registration District No. 3

Primary Registration District No. 1005

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert E Glenn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 12 (Day) 1916 (Year)

7. AGE: ....Yrs. 4 Mos. 5 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Robert E Glenn

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Dora Watkins

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert E Glenn

(Address) Caldwell,

15. Filed 9-18-1916 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12- 1916, to Sept. 17- 1916, that I last saw h.im alive on Sept. 17- 1916, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Intestion -

(Duration) Yrs. 3 mos. ..... ds.

Contributory (Secondary) Indigestion -

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John S. Meyer M. D.

9/18- 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lawn Boise Cemetery — DATE OF BURIAL: 9/19 1916

20. UNDERTAKER: W. A. Dyer — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15468

Registered No. 64

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Caldwell (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information. Route R 1

Registration District No. 3

Primary Registration District No. 2005

2. FULL NAME William N. Gragg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. (Month) 6 (Day) 1843 (Year)

7. AGE: 72 Yrs. 11 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: R.P. Gragg

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Dent

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J.W. Gragg
(Address) Caldwell, Ida. R.F.D. 4

15. Filed 9-17- 1916 John F. Kreyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 9 1916, to Sept. 16 1916, that I last saw him alive on Sept 9 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C.M. Raley M. D.

Sept 17 1916 (Address) Caldwell Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverside Cemetery — DATE OF BURIAL: 9-17 1916

20. UNDERTAKER: W.A. Dye — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15469

Registered No. 63

Registration District No. 3

Primary Registration District No. 1005

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

2. FULL NAME Laura Murad Westcott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 28 (Day) 1911 (Year)

7. AGE: 4 Yrs. 8 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER C J Westcott

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Jean Garretson

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C J Westcott

(Address) Caldwell Idaho

15. Filed 9-17- 1916 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1916, to Sept 15 1916, that I last saw her alive on Sept 15 1916 and that death occured on the date stated above, at 11:40 P.M.

The CAUSE OF DEATH* was as follows:

Valvular lesion of heart

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. D. Miller M. D.

9-16 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Story City Iowa

DATE OF BURIAL: 9-17 1916

20. UNDERTAKER: W. C. Dyer

ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boise
City of Placerville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 2019
(No. ....., ... St.)

File No. 15470
Registered No. 39
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Williams Henry Goodman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Mar (Month) 5 (Day) 1863 (Year)

7. AGE
53 yrs. 6 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Rancher.
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER August Goodman

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15.
Filed ..... 191 6 May Fitz Deputy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Sept (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 6, to 1916, that I last saw him alive on 1916, and that death occurred on the date stated above, at 5:20 P. M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. G. Fitz M. D.
Sept-24 1916 (Address) Placerville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett.	Sept-27. 1916

20. UNDERTAKER	ADDRESS
/	Emmett.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS – YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 2086

File No. 15471
Registered No. .....

2. FULL NAME Nettie Dunfee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Aug (Month) 15 (Day) 1873 (Year)
7. AGE: 43 Yrs. 1 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Utah Co Utah
10. NAME OF FATHER: James Dunfee
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Kate Brackenberry
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Dunfee
(Address) Twin Falls Ida
15. Filed 9-19 1916 GG Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 18 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1916 to Sept 18 1916, that I last saw h[illegible] alive on Sept 18 1916 and that death occured on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows: Myocarditis
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) X
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) C. E. Dunfee M. D.
9/18 1916 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos. ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Almo — DATE OF BURIAL: 9-20 1916
20. UNDERTAKER: None — ADDRESS

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2786
File No. 15472
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geraldine Annabelle Carson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 11 (Day) 1916 (Year)

7. AGE ..... Yrs. 4 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Filer.

10. NAME OF FATHER Frank Carson

11. BIRTHPLACE OF FATHER (State or Country) Warren Co Ill

12. MAIDEN NAME OF MOTHER Lillian Snodely

13. BIRTHPLACE OF MOTHER (State or Country) Nebr

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Carson
(Address) Filer

15. Filed 9/5 1916 A. A. Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1916, to Sept 4 1916, that I last saw him alive on Sept 4 1916 and that death occured on the date stated above, at 8 a. M.
The CAUSE OF DEATH* was as follows: Gastro enteritis

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) C. M. Symes M. D.
19..... (Address) Filer Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Cemet — DATE OF BURIAL: 9/5 1916

20. UNDERTAKER: F E Drake — ADDRESS: Filer Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 86

Primary Registration District No. 2112

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15473

Registered No. 11

1. PLACE OF DEATH.

County of Washington

City of Weiser

(No. 2, St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Keifer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 27 (Day) 1876 (Year)

7. AGE: 40 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Peter Keifer

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary Stohl

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs George Keifer

(Address) Weiser Idaho

15. Filed 9-6 1916

W. R. Hamilton
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1916, to Sept 3 1916, that I last saw him alive on Sept 3 1916, and that death occured on the date stated above, at 6-30 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James A Young M. D.

Sept 5 1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos. 4 days

Where was disease contracted if not at place of death? On Monroe Creek

Former or usual residence On Monroe Creek

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho — DATE OF BURIAL: 9-5 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15474

Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 212

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret E. Adams

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Whr

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 10 (Day) 1888 (Year)

7. AGE: 28 Yrs. 7 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: D.W. Randan

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Clara James

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Clara Feldhausen

(Address) 132 North Grand St.

15. Filed 9-27 1916

Pocatello Idaho

W. R. Hamilton
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 25th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at about 2 P.M.

The CAUSE OF DEATH* was as follows:

Drowning Suicide

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James J. McCann Coroner M. D.

9/27 1916 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser — DATE OF BURIAL: 9/27 1916

20. UNDERTAKER: Thos. McCann — ADDRESS: Weiser Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15475

Registered No. 12

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 1010

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel C. Coles.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. (Month) 3 (Day) 1862 (Year)

7. AGE: 54 Yrs. — Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Blindsman

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: George W. Coles

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Nancy E. Coles

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. M. Coles

(Address) Weiser, Idaho

15. Filed 9-12 1916 W. R. Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1916, to Sept 10 1916, that I last saw h[im] alive on Sept 10 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James A Young M. D.

Sept 12 1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Cemetery — DATE OF BURIAL: 9/11 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Washington

City of Meiser

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86

Primary Registration District No. 1010

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15476

Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Cornell Gordon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Apr. (Month) 28 (Day) 1913 (Year)

7. AGE 3 Yrs. 4 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Heaven Ida

10. NAME OF FATHER A. C. Gordon

11. BIRTHPLACE OF FATHER (State or Country) Mich

12. MAIDEN NAME OF MOTHER Bessie B Hamilton

13. BIRTHPLACE OF MOTHER (State or Country) Denver Col

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A C Gordon

(Address) .....

15. Filed 9-16 1916 W. R. Hamilton Local Registrar

SVMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/15 1916, to 9/15 1916, that I last saw h[illegible] alive on 9/15 1916, and that death occured on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

Diarrhoea and Enteritis

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Lawrence O Freeman M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meiser Cemetery — DATE OF BURIAL: 9/17 1916

20. UNDERTAKER: A. J. Cordell — ADDRESS: Meiser

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 15477
Registered No. 14

1. PLACE OF DEATH.
County of Washington
City of Weiser (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel Estelle Kemp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Wte
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 1 (Day) ..... (Year)

7. AGE: 13 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Albert M. Kemp

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Martha Boardman

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. M. Kemp
(Address) Weiser Idaho.

15. Filed 9-22 1916 W. R. Hamilton Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) — 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1916, to Sept 21 1916, that I last saw h[er] alive on Sept 21 1916, and that death occured on the date stated above, at 10P M.

The CAUSE OF DEATH* was as follows:

Pneumonia Paralysis

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) Typhoid

(Duration) ..... yrs. ..... mos. 21 ds.

(Signed) C B Dudley M. D.

19..... (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos. 14 days
Where was disease contracted if not at place of death? Communicated
Former or usual residence Weiser Ida

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho — DATE OF BURIAL: 9/23 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15478

Registered No. 15-

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Weiser

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1010

Primary Registration District No. 86

2. FULL NAME John E. Hubbard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. (Month) 13 (Day) 1886 (Year)

7. AGE: 30 Yrs. 5 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Railroad Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Nebr.

10. NAME OF FATHER: Jno Hubbard,

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Mitchell

13. BIRTHPLACE OF MOTHER (State or Country): Delaware

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William Hubbard
(Address) New Platte Okla

15.
Filed 9-23 1916
W. R. Hamilton
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept. (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1916, to Sept 23 1916, that I last saw him alive on Sept 22 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Paralysis Respiration & Heart Failure

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Concussion Brain

(Duration ..... yrs. ..... mos. 12 ds.

(Signed) C. C. Dudley M. D.

19..... (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 11 days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? New Meadows

Former or usual residence New Meadows Ida

19. PLACE OF BURIAL OR REMOVAL: New Meadows Ida — DATE OF BURIAL: Sept 23 1916

20. UNDERTAKER: Northern McCann — ADDRESS: Weiser Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
(No. ..... , ... St.)

File No. 15479
Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Washington
City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jong Poon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mongolian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: — — — (Month) (Day) 1 (Year)

7. AGE: 57 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laundryman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Duck Lee

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Jong Poon Weiser Ida

15.
Filed 10-2 1916 W. P. Hamilton Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 1st 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 5 1916, to October 1 1916, that I last saw him alive on October 1 1916 and that death occured on the date stated above, at 11 00 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James A Young M. D.
Oct 2 1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: Oct 2 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15480
Registered No. 11

1. PLACE OF DEATH.
County of ~~XXXXXX~~ Nezperce
City of Gifford
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 92
Primary Registration District No. 2170
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Oscar E. Reinhart

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): married

6. DATE OF BIRTH: May (Month) 6 (Day) 1863 (Year)

7. AGE: 53 yrs. 4 mos. 5 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: George A. Reinhart

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Harriet Denney

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Kole
(Address) Gifford Ida

15. Filed 9-12 1916 E. E. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 11 (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/11 1916 to 9/11 1916, that I last saw him alive on 9/11 1916, and that death occurred on the date stated above, at 9¼ M.

The CAUSE OF DEATH* was as follows:
Suicide by cutting throat

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E.E.Watts M. D.
9/11 1916 (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Reubens Ida
DATE OF BURIAL: 9/12 1916

20. UNDERTAKER: A.L.Fisher (acting)
ADDRESS: Reubens

SYMS - YORK CO., PTRS. & BDRS. 19750

Mail or Deliver This Certificate to Your Local Registrar. Not to the State Board of Health. 15481

WASHINGTON STATE BOARD OF HEALTH

Record No. 2141

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No. ____

Registered No. 33

PLACE OF DEATH
County of Latah
City or Town of Moscow
Registration Dist. No. 61

(No. ____, ____ St.; ____ Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information."]

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

FULL NAME Lacey Edward Holden

Personal and Statistical Particulars

3 Sex: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (Write the word): Single

6 Date of Birth: March (Month) 27 (Day), 1902 (Year)

7 Age: 14 yrs. 6 mos. 12 ds.
If LESS than 1 day, ____ hrs. or ____ min.?

8 Occupation
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business or establishment in which employed (or employer): General Laborer.

9 Birthplace (State or country): Oregon.

PARENTS

10 Name of Father: John R. Holden

11 Birthplace of Father (State or country): Utah.

12 Maiden name of Mother: Sarah E. Harrington

13 Birthplace of Mother (State or country): U. S.

14 The above is true to the best of my knowledge
(Informant) George E Holden
(Address) moscow

15 Filed Sept 16, 1916 D F Rae Registrar.

Medical Certificate of Death

16 Date of Death: 9 (Month) 17 (Day), 1916 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ____, 191__, to ____, 191__, that I last saw h__ alive on ____, 191__, and that death occurred, on the date above, at 4 30 P.M.
The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Walter A. Burg, M. D.
9-17, 1916 (Address) Moscow

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 Length of Residence (For Hospitals, Institutions, Transients, or Recent Residents)
At Place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs ____ mos. ____ ds.
Where was disease contracted, if not at place of death? ____
Former or usual residence ____

19 ~~Place of Burial~~ or Removal: Moscow Idaho. Date of Burial: Sept 19, 1916

20 Undertaker: Ellen Grice. Address: moscow Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. Hotel Idaho St.)

File No. 15482
Registered No. 57
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gustav Johanson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) Know (Day) 1894 (Year)

7. AGE: 22 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm Hand
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweeden

10. NAME OF FATHER: Johan Andersone

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. A. Anderson
(Address) Moscow Idaho

15. Filed Sept 24 1916 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at [redacted]

The CAUSE OF DEATH* was as follows:

Suicide. Revolver Wound in the Head.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L B McCarter Coroner [redacted]
9/23 1916 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence. Hamson Idaho

19. PLACE OF BURIAL OR [redacted] Moscow | DATE OF BURIAL Sept 24 1916

20. UNDERTAKER Glen Grice | ADDRESS moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 15483
Registered No. 56

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Tina Lundquist
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Nov (Month) 26 (Day) 1831 (Year)

7. AGE: 84 yrs. 9 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweeden

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. G. Lundquist
(Address) moscow

15. Filed Sept 19 1916 — T. L. Rae, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 9 (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Dau Mrs. Lundquist
after death — Think cause
of death — senile decay —
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Dodd M. D.
9-18 1916 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Moscow — DATE OF BURIAL: Sept 19 1916

20. UNDERTAKER: Glen Grice — ADDRESS: moscow

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2128
File No. 15484
Registered No.

1. PLACE OF DEATH.
County of Ida.
City of Winona
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Everette Wilber Higgins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	Single

6. DATE OF BIRTH: 9 (Month) 12 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ... 3 ... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: J. Leslie Higgins

11. BIRTHPLACE OF FATHER (State or Country): Ills.

12. MAIDEN NAME OF MOTHER: Nadine N. Hunt.

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Leslie Higgins
(Address) Winona

15. Filed 9/12 1916 W. F. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/12 1916, to same 1916 that I last saw him alive on 9/12 1916, and that death occurred on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH* was as follows:
Lack of Vitality - Possibly a little premature term.
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. McMahan M. D.
9/8 1916 (Address) Kamiah, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Winona Ida. DATE OF BURIAL: 9/13 1916

20. UNDERTAKER: J. Leslie Higgins ADDRESS: Winona Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15485
Registered No.

1. PLACE OF DEATH
County of Idaho
City of Kamiah

Registration District No. 49
Primary Registration District No. 212
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Baby Parsons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Aug. (Month) 31 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: That of a child
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho county

10. NAME OF FATHER: Jude Parsons

11. BIRTHPLACE OF FATHER (State or Country): Kamiah Ida.

12. MAIDEN NAME OF MOTHER: Letitia Hages

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jude Parsons.
(Address) Kamiah, Ida.

15.
Filed 9/5 1916 W. F. McMahan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4th 1916, to (Date) Sept 4 1916
that I last saw h[illegible] alive on Sept 4 1916
and that death occurred on the date stated above, at 3:30 P.M.
The CAUSE OF DEATH* was as follows:
[illegible] Umbilical Hemorrhage
..... (Duration) ..... yrs. ..... mos. 3 hours
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. O. Johnson M. D.
Sept 5 1916 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind. Cem No 1, DATE OF BURIAL: 9/5 1916

20. UNDERTAKER: C. J. Johnson ADDRESS: Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Kamiah
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19
Primary Registration District No. 2128
(No. ..... , ... St.)

File No. 15486
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura Mary Morris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White,
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 21 (Day) 1910 (Year)

7. AGE: 5 yrs. 8 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stat- of a child
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: A E Morris.

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Anna Simmons,

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A E Morris,
(Address) Kamiah

15.
Filed 8/19 1916 W. L. McMeekin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 18th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1916, to August 1916, that I last saw h.. alive on 8/18 1916, and that death occurred on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:
Encephalitis
Chorea
Acute Articular Rheumatism
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
(Duration) ..... yrs. 1 mos. 18 ds.
(Signed) C. O. Bryson M. D.
8/19 1916 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Old Cemetery — DATE OF BURIAL: 8/20 1916

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kamiah Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO. PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2128
File No. 15487
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Winona (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Morell Lamb
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Married (or Widowed)

6. DATE OF BIRTH
Jan (Month) 8 (Day) 1841 (Year)

7. AGE
75 yrs. 8 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Galand Lamb

11. BIRTHPLACE OF FATHER (State or Country) Mass

12. MAIDEN NAME OF MOTHER Lucy Weston

13. BIRTHPLACE OF MOTHER (State or Country) dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Effie Lamb Stout.
(Address) Waverly Wash.

15.
Filed 9/24 1916 W. H. McMahan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
9 (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1914 191 , to 9/23/ 1916
that I last saw him alive on 9/22/ 1916,
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. McMahan M. D.
9/24 1916 (Address) Kamiah Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hopewell Cemetry	9/25 1916

20. UNDERTAKER	ADDRESS
C. J. Johnson	Kamiah Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 15489
Registered No. 38

1. PLACE OF DEATH.
County of Madison
City of Sugar
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reid - A. Whitaker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Boy
6. DATE OF BIRTH. April (Month) 19 (Day) 1907 (Year)
7. AGE: 9 Yrs. 3 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Salt Lake City
10. NAME OF FATHER: J. E. Whitaker
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Lucy Reid
13. BIRTHPLACE OF MOTHER (State or Country): Idaho (Stone)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lucy Allred.
(Address) Sugar
15. Filed 8/16 191 6 G. G. Cope Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 1 (Day) 191 6 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 191 6, to Aug 10th 191 6 that I last saw h... alive on Aug 1 191 6, and that death occured on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
Dropsy
(Duration) 4 Yrs. — mos. ds.
Contributory (Secondary)
(Duration ..... mos. ds.
(Signed) J. C. Young M. D.
19 ..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar — DATE OF BURIAL: 8/7 191 6
20. UNDERTAKER: J. C. Young — ADDRESS: Rexburg

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Iowa
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 600

Primary Registration District No. 2178

File No. 15490

County of Madison

City of Winterset (No. ....., ... St.)

Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William J. Vance

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 7 (Day) 1852 (Year)

7. AGE: 64 Yrs. 3 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: James Vance

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Susan Brown

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Vance - Pa Wyong

(Address) Sugar

15. Filed 8/12 1916 G L Cooper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1st 1916, to July 31 1916, that I last saw him alive on June 30 1916, and that death occured on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus and Enlargement of Liver

(Duration) 2 Yrs. 3 mos. 10 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W P Stephenson M. D.

1916 (Address) Dexter

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar — DATE OF BURIAL: 8/12 1916

20. UNDERTAKER: J Wyong — ADDRESS: Ruby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 15491
Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Madison

City of Rigby

2. FULL NAME Adam Smith

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 6 (Day) 1825 (Year)

7. AGE: 91 Yrs. 2 Mos. 29 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Famer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Adam Smith

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Melisa Henry

13. BIRTHPLACE OF MOTHER (State or Country) W. Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Zorayda M. Avery
(Address) Rigby

15. Filed 8/16 1916 — O. L. Eaton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/4 1916, to 8-6 1916, that I last saw h[illegible] alive on 8-6-1916, and that death occured on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:
No particular disease

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. L. Eaton M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: 8/8 1916

20. UNDERTAKER: [illegible] Young — ADDRESS: Rigby

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 150
Primary Registration District No. 2178
(No. .....) ..... St.)

File No. 15492
Registered No. 41

1. PLACE OF DEATH.
County of Jefferson
City of Lorenzo
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rose Robertson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: White

5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.): Married

6. DATE OF BIRTH. Feb. (Month) 5 (Day) 1887 (Year)

7. AGE: 29 Yrs. 6 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Fred Roth

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Mary - Wallie

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. B. Roth
(Address) Lorenzo

15. Filed 8/16 1916 G. G. Espe
Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1916, to Aug 15 1916, that I last saw her alive on Aug 15 1916, and that death occured on the date stated above, at 11a M.

The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Drs. Melton, Fisher & Walker M. D.
19.... (Address) Menan, Rigby, Ryburn Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Archer
DATE OF BURIAL: 8/17 1916

20. UNDERTAKER: Wyoming
ADDRESS: Rigby

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 15493
Registered No. 42

1. PLACE OF DEATH.
County of Fremont
City of Wilford
(No. ..... Mc Arthur)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Elizabeth McArthur
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH.
Nov (Month) 12 (Day) 1850 (Year)

7. AGE
65 Yrs. 9 Mos. 12 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Widow
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Jacob F Abbott

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Martha Jane Bickmore

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo M Arthur
(Address) Wilford

15. Filed 8-25 1916
G B Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pulmonic Stenosis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Morfitt M. D.

19.... (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilford — DATE OF BURIAL: Aug 26 1916

20. UNDERTAKER: John Phillips — ADDRESS: Rex.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Sykes - York Co., Print. & Supp. 24854

FORM V. S. No. 5-25 M. 1-16-13

9/1/16

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 15494
Registered No. 43

1. PLACE OF DEATH.
County of Madison
City of Sugar
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donovan A. Bramwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.): Boy

6. DATE OF BIRTH: April (Month) 14 (Day) 1911 (Year)

7. AGE: 5 Yrs. 4 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Babe
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Preston

10. NAME OF FATHER: Adna E. Bramwell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Viola Brown

13. BIRTHPLACE OF MOTHER (State or Country): Oxford Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Adna E. Bramwell
(Address) Canvas, Idaho

15. Filed 9/2 1916 L. G. Teeples Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 1. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) ..... Yrs. ..... mos. 30 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. G. Teeples M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Plano — DATE OF BURIAL: 9/3 1916

20. UNDERTAKER: J. Rigsby — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 217
(No. ..... St.)

File No. 15495
Registered No. 44

1. PLACE OF DEATH.
County of Mad.
City of Salem

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ivan J. Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept (Month) 12 (Day) 1915 (Year)

7. AGE: ....1....Yrs. ....Mos. 11 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Salem Ida

10. NAME OF FATHER Jas. R. Harris

11. BIRTHPLACE OF FATHER (State or Country) America

12. MAIDEN NAME OF MOTHER Adelaide Calaway

13. BIRTHPLACE OF MOTHER (State or Country) America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jas R. Harris
(Address) Salem

15. Filed 9-2 1916 G E Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....191....., to .....191....., that I last saw h.....alive on .....191....., and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Septicaemia

.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary) .....
.....(Duration .....yrs. .....mos. .....ds.
(Signed) G R Thorpe M. D.
.....19..... (Address) Sugar City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar City — DATE OF BURIAL: 9/3 1916

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYAM - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. .... St.)

File No. 15496
Registered No. 45

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Caroline B. Larson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Jan (Month) 30 (Day) 1854 (Year)

7. AGE: 62 Yrs. 7 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Ole Halvarson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Kaya Jansdater

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Julius Halvarson
(Address) Rexburg

15. Filed 9-9 1916
G. L. Espe
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
9 (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-4 1916, to 9-8 1916, that I last saw h- alive on 9-6 1916, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Embolus

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) G. L. Espe M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg
DATE OF BURIAL: 9/11 1916

20. UNDERTAKER: John Phillips
ADDRESS: Rexburg

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 100

County of Fremont Primary Registration District No. 2178

City of Teton (No. ....., ... St.)

File No. 15497

Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald F Rohlfing

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov (Month) 14 (Day) 1910 (Year)

7. AGE: 5 Yrs. 9 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Robert Wahlfing

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Anna Mable Sattmann

13. BIRTHPLACE OF MOTHER (State or Country) Indiana U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Wahlfing

(Address) Teton

15. Filed 9-16 1916 G. L. Estes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 1[illegible] (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Thrupp M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. Anthony — DATE OF BURIAL: 9/14 1916

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 15498
Registered No. 78

1. PLACE OF DEATH.
County of Madison
City of Sugar
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Olive Hill Estupp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. Feb. (Month) 27 (Day) 1831 (Year)
7. AGE: 85 Yrs. 6 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): America
10. NAME OF FATHER: Wm Hill
11. BIRTHPLACE OF FATHER (State or Country): America
12. MAIDEN NAME OF MOTHER: Mary Hill
13. BIRTHPLACE OF MOTHER (State or Country): America
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robt W. Estupp
(Address) Sugar
15. Filed 9-22 1916 G. E. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 21 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1916, to Sept 20 1916, that I last saw h[illegible] alive on Sept 20 1916, and that death occured on the date stated above, at 3 30 P.M.
The CAUSE OF DEATH* was as follows:
Stroke and Senility
Jaundice (Duration) 1 Yrs. 2 mos. 3 ds.
Contributory (Secondary) Senility
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. L. Espe M. D.
19..... (Address) Dayton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar City — DATE OF BURIAL: 9/23 1916
20. UNDERTAKER: John Phillips — ADDRESS: Rex

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ROBS. 24658

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

9/27/16

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 15499
Registered No. 49

1. PLACE OF DEATH.
County of Jefferson
City of Annis

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Weir

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. ~~SINGLE, MARRIED~~, WIDOWED ~~OR DIVORCED~~. (Write the word.)

6. DATE OF BIRTH. Sept (Month) 17 (Day) 1818 (Year)

7. AGE: 98 Yrs. 7m Mos. 10 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER David - Winter

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S. J. Merrell
(Address) Annis, Ida

15. Filed 9/27 1916 G. H. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....1916....., to .....1916.....,
that I last saw h.....alive on .....1916.....,
and that death occured on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Old age

.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary) .....
.....(Duration) .....yrs. .....mos. .....ds.
(Signed) G. H. Espe M. D.
1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Annis
DATE OF BURIAL: 9/29 1916

20. UNDERTAKER: J. Rooney
ADDRESS: Rigby

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 15500
Registered No. 47

1. PLACE OF DEATH.
County of Madison
City of Rex. (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Zina F. Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 27 (Day) 1914 (Year)

7. AGE ..... Yrs. 2 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Rex.

10. NAME OF FATHER L. A. Harris

11. BIRTHPLACE OF FATHER (State or Country) America

12. MAIDEN NAME OF MOTHER Zina Cate

13. BIRTHPLACE OF MOTHER (State or Country) America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. J. Lammers
(Address) Rex

15. Filed 9-19 1916 G. G. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-11 1916, to 9-18 1916, that I last saw h[illegible] alive on 9-17 1916, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) G. G. Espe M. D.

.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: John S Phillips — DATE OF BURIAL: 9/19 1916

20. UNDERTAKER: Sugar City — ADDRESS: Rex

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 15501
Registered No. 69

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pharus Sorensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 5 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..8.. hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Nephi Sorensen

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Linda Dean

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ephraim Sorensen
(Address) .....

15. Filed Sept 5 1916 W. E. Dalzell Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1916, to Sept 5 1916, that I last saw h.im alive on Sept 5 1916, and that death occured on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W W Beck M. D.

9/5 1916 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Groveland Cem. DATE OF BURIAL: Sept 6 1916

20. UNDERTAKER: Ephraim Sorensen ADDRESS: Blackfoot Route 4

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ....., ... St.)

Registration District No. 121
Primary Registration District No. 2194

File No. 15502
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl M. Whiting

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Given) July 31 (Month) (Day) 1916 (Year)

7. AGE: — Yrs. 1 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Lucius Whiting

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Pearl Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lucius Whiting
(Address) Blackfoot R 1

15. Filed Sept 8th 1916 W. E. Pattie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1916, to Sept 7 1916, that I last saw him alive on Sept 5 1916, and that death occured on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Enlarged Thyroid Gland

(Duration) — Yrs. 1 mos. 8 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Beck M. D.

9/8 1916 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland Cem — DATE OF BURIAL: Sept 9 1916

20. UNDERTAKER: Lucius Whiting — ADDRESS: Blackfoot Route 1 Ida

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 2124

(No. South Idaho Sanitarium)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15503

Registered No. 68

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lois Mimsaugh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: 83 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dorothy Bryants

(Address) Blackfoot Idaho

15. Filed Sep. 3rd 1916

M. E. Davis
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18 1916, to Sept. 3 1916, that I last saw her alive on Sept. 3 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Extravasion Serum
Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dorothy Bryants M. D.

9-3 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 5 mos. 16 days. In the State 73 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Unknown

Former or usual residence St. Anthony Idaho

19. PLACE OF BURIAL OR REMOVAL: St. Anthony

DATE OF BURIAL 191

20. UNDERTAKER: E. Peck

ADDRESS: Blackfoot

46

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 15504
Registered No. 70

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel S. Hammond

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. April (Month) 15 (Day) 1853 (Year)

7. AGE: 63 Yrs. 4 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farming
(b) General nature of industry, business, or establishment in which employed (or employer)..... General farming

9. BIRTHPLACE (State or Country) Sandwich Islands

10. NAME OF FATHER: Francis A. Hammond

11. BIRTHPLACE OF FATHER (State or Country): U. S. A.

12. MAIDEN NAME OF MOTHER: Mary Dillworth

13. BIRTHPLACE OF MOTHER (State or Country): U. S. A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Samuel S. Hammond Jr
(Address) Blackfoot Ida.

15. Filed Sept 8th 1916 — M. E. Dutrie, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1916, to Sept 7 1916, that I last saw him alive on Aug 15 1916, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(Duration) — Yrs. 3 mos. — ds.

Contributory (Secondary) Mitral stenosis

(Duration not known ds.

(Signed) W W Beck M. D.

9/8 1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moreland Idaho — DATE OF BURIAL: Sept 10 1916

20. UNDERTAKER: Samuel S. Hammond Jr — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 15505
Registered No. 12

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. Blackfoot RFD 2 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joan Jennett Lulson Turpin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. May (Month) 14 (Day) 1848 (Year)

7. AGE: 68 Yrs. 3 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Wales

10. NAME OF FATHER: Richard Lulsen

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hannah Francis Mather

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. E. Turpin
(Address) Blackfoot Idaho

15. Filed Sep 8 1916
W. C. Davis
Local Registrar

SYMS - YORK CO., PTRS. & BKBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Death 191 , to 191 , that I last saw her alive on investigated 191 , and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: Old age

Acute Asthenia

(Duration) 5 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration yrs. Coroner mos. ds.

(Signed) J. B. Davis Phys. M. D.

1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utah — DATE OF BURIAL 191

20. UNDERTAKER: E. J. Peck — ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 15506
Registered No. 13

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. Blackfoot R.F.D. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dale Lee Beasley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. February (Month) 1 (Day) 1899 (Year)

7. AGE: 17 Yrs. 7 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: Isaac Lee Beasley

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Elsie May Beyers

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elsie May Beasley
(Address) Blackfoot Idaho

15. Filed Sept 12 1916
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24859

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1916, to Sept 12 1916, that I last saw him alive on Sept 12 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(Duration) — Yrs. — mos. 10 ds.

Contributory (Secondary) Appendicitis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) Ft Hall Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grim Hill Cemetery | DATE OF BURIAL 191

20. UNDERTAKER: E J Peck | ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 15507
Registered No. 74

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot (No. Blackfoot Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 1st (Day) 1876 (Year)

7. AGE: 40 Yrs. 6 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Lodging house
(b) General nature of industry, business, or establishment in which employed (or employer) Proprietor

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Mary Jones
(Address) 136 S. 1st E Pocatello

15. Filed Sep 14th 1916. M. E. Gates Local Registrar Ida

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:
Internal Hemorrhage
from Gun shot Wound
Coronas Jury's Verdict
Homicidal
(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E J Puck Coroner M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Osawatomie Kansas | DATE OF BURIAL 191...

20. UNDERTAKER: E J Puck | ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

Primary Registration District No. 2194

File No. 15508

Registered No. 73

County of Bingham

City of Blackfoot (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie B. Hall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. (Month) ..... (Day) 1891 (Year)

7. AGE: 21 Yrs. 11 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ky

10. NAME OF FATHER Wm Parker

11. BIRTHPLACE OF FATHER (State or Country) Ky

12. MAIDEN NAME OF MOTHER India Smith

13. BIRTHPLACE OF MOTHER (State or Country) Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Hall

(Address) .....

15. Filed Sept 20 1916 M. E. Petrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1916, to Sept 13 1916, that I last saw he alive on Sept 13 1916, and that death occured on ~~the date stated above~~, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. A. O'Mayhall M. D.

9/20 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moreland Idaho — DATE OF BURIAL: Sept 20 1916

20. UNDERTAKER: Jack Hall — ADDRESS: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STATE - YORK CO., PTRS. & BKRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 2194

City of Blackfoot

(No. 80, Snake River St.)

File No. 15509

Registered No. 76

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kate Martini

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 29 (Day) 1908 (Year)

7. AGE: 8 Yrs. 1 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: Jacob Martini

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Fannie Geese

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jacob Martini
(Address) Faban Idaho

15. Filed Sept. 24 1916

M. E. Clarke
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw Kate alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
accidental drowning
Swift Ranch near Blackfoot
Body found Sept 23 1916
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) E. J. Peck Coroner M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Faban Idaho — DATE OF BURIAL: Sept 26 1916

20. UNDERTAKER: E. J. Peck — ADDRESS: Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 15510
Registered No. 77

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agnes Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. August 28, 1915 (Month) (Day) (Year)

7. AGE: 1 Yrs. X Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jens. P. M. Jensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: annie C. Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jens P. M. Jensen
(Address) Blackfoot Ida. R.D. 2

15. Filed Sept. 26 1916 M. E. Petrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 26 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23 1916, to Sept 26 1916, that I last saw h.er alive on Sept 23 1916, and that death occured on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:

Ileo colitis

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Geek M. D.
9/26/16 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverside - Thomas
DATE OF BURIAL: Sept. 28 1916

20. UNDERTAKER: Jens P. M. Jensen
ADDRESS: Blackfoot Ida. Rt. 2

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15511

Registered No. 78

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2199

(No. Riverside Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank C. Hutchinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 8 (Day) 1894. (Year)

7. AGE: 22 Yrs. 3 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John P. Hutchinson

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Kate Dolson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate Hutchinson

(Address) Blackfoot, Idaho

15.

Filed Sep 27 1916

M. E. White
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1916, to Sept 26 1916, that I last saw h[illegible] alive on Sept 26 1916, and that death occured on the date stated above, at 3 30 P. M.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(Duration) — Yrs. 3 mos. — ds.

Contributory (Secondary) Sun Stroke

(Duration yrs. 3 mos. ds.

(Signed) F. C. Mitchell M. D.

9/26 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Cemetery — DATE OF BURIAL: Sep 28 1916

20. UNDERTAKER: E. J. Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 0194
File No. 15512
Registered No. 199

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bernice Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 4th (Day) 1914 (Year)

7. AGE: 2 Yrs. 4 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fort Bingham Co Idaho

10. NAME OF FATHER: H.K. Williams

11. BIRTHPLACE OF FATHER (State or Country): Colo.

12. MAIDEN NAME OF MOTHER: Margaret Burrell

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) X H.K. Williams
(Address) Shelley Idaho R.F.D. 2

15. Filed Sept 21 1916 M.E. Patrie Local Registrar

SYMS - YORK CO., PTRS. & BNRS. 24659

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ Investigated death ..... 191..., to ..... 191...,
~~that I last saw h... alive on ..... 191...,~~
and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Drowned

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Coroner
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: G | DATE OF BURIAL ..... 191...

20. UNDERTAKER: X H.K. Williams | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 131
Primary Registration District No. 2194
File No. 15513
Registered No. 80

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charlie Mike

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Unknown

6. DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7. AGE: Unknown Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Unknown
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. M. Poyner
(Address) Blackfoot - Idaho

15. Filed Sept 30 1916 W. E. Patrick Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 21 (Day) 1915 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 6 1915, to Oct 21 1915, that I last saw him alive on Oct 21 1915, and that death occured on the date stated above, at 11 10 M.

The CAUSE OF DEATH* was as follows:
General Paralysis of the Insane

Unknown (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. M. Poyner M. D.
19..... (Address) Blackfoot - Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 2 mos. 14 days In the Unknown State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?.....
Former or usual residence Unknown

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Asylum Cemetery, Blackfoot Ida	Oct 22 1915
20. UNDERTAKER	ADDRESS
Julius L. Greer. Supervisor.	Eureka Asylum Blackfoot Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2274
(No. ..... St.)

File No. 15514
Registered No. .....

1. PLACE OF DEATH.
County of Benewah
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME E. D. McGraw

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 55 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer in Woods.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. Desmond
(Address) St Maries Ida.

15. Filed Sept. 12 1916 H E Smith Local Registrar

SYMS - YORK CO., MFRS. & BOOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1916, to Sept 11 1916, that I last saw him alive on Sept 11 1916, and that death occured on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:
Sarcoma of Jaw.
..... (Duration) ..... Yrs. 6 mos. ..... ds.
Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D. Desmond M. D.
9/12 1916 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Sept. 12 1916

20. UNDERTAKER: H E Smith — ADDRESS: St M.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. .... St.)

File No. 15515
Registered No. .....

1. PLACE OF DEATH.

County of Benewah
City of St Maries

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Owen Mulder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
May (Month) 5 (Day) 1914 (Year)

7. AGE
2 Yrs. 4 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): St Maries

10. NAME OF FATHER: Cornell Mulder

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Mollie Payne

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C Mulder
(Address) St Maries

15. Filed Sept. 30 1916 H E Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept. (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1916, to Sept 29 1916, that I last saw him alive on Sept 29 1916, and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) — Yrs. — mos. 9 ds.

Contributory (Secondary) Pertussis

(Duration — yrs. — mos. 7 ds.

(Signed) A S Platt M. D.

Sept 29 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Sept. 30 1916

20. UNDERTAKER: H E Smith — ADDRESS: St M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PRTS. & BKRS. 24659

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15516

Registered No. 915

1. PLACE OF DEATH.

County of Boundary

City of Sandpoint (No. ..... St.)

Registration District No. 78

Primary Registration District No. 2153

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A. Hausnick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 28 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Fisherman

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E M Byers

(Address) S. P.

15. Filed Sept 1 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... Dec ..... (Month) ..... (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h...alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) W. M. Knapp M. D.

9/1 19 16 (Address) Kaper Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Id. | DATE OF BURIAL: Sept 1916

20. UNDERTAKER: E M Byers | ADDRESS: S. P.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15517

Registered No. 566

1. PLACE OF DEATH.

County of Bonner

City of Sandpoint (No. ....., ... St.)

Registration District No. 7 8

Primary Registration District No. 2153

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna B Dunnigan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 18 (Day) 1904 (Year)

7. AGE: 11 Yrs. 11 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: ~~Student~~

(b) General nature of industry, business, or establishment in which employed (or employer): Was always an epileptic never went to school or any work

9. BIRTHPLACE (State or Country): Mont.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dan Dunnigan

(Address) .....

15.

Filed Sept 6 191 6 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 5 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from I saw him while working at ..... 191..., that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Epileptic - Congenital - Was born had short Cord. as nothum on left hand no thum on right hand developed from end of wrist

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) as above

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.

19..... (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho

DATE OF BURIAL: 9/8 191 6

20. UNDERTAKER: E M Brosier

ADDRESS: S P.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24653

FORM P. H. S. No. 5 Rev. M. 1916

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 172
County of Bingham
Primary Registration District No. 2133
File No. 1215
City of Sanpoint (No. ..... St.)
Registered No. 615

If death occurs away from usual residence, give facts called for under special information. Hope.

2. FULL NAME Sadie V. Boyington.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 9 (Day) 1868 (Year)

7. AGE: 47 Yrs. 11 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y. State

10. NAME OF FATHER: Hiram G. Smith

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: — — —

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward D Boyington
(Address) Hope, Idaho

15. Filed Sept 16 1916 M McKinney Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6 1916, to Sept 16th 1916, that I last saw h.er alive on Sept 16th 1916, and that death occured on the date stated above, at 7.15 P.M.

The CAUSE OF DEATH* was as follows:
Aortic Stenosis

(Duration) 1 Yrs. — mos. — ds.
Contributory (Secondary) Acute Interstitial Nephritis

(Duration ..... yrs. ..... mos. 4 ds.
(Signed) Houston E Snyder M. D.
9-16 1916 (Address) Hope Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sterns Point Wis — DATE OF BURIAL: 9/18 1916

20. UNDERTAKER: E M Brower — ADDRESS: S. P.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78
Primary Registration District No. 2155
File No. 15519
Registered No. 618

County of Bonner
City of Hope (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. M. Lloyd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 64 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: James Lloyd

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Margaret Hughes

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J J Lloyd
(Address) .....

15. Filed Sept 18 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1916, to Sept 17 1916, that I last saw him alive on Sept 17 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrage
due to arterial sclerosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W W McKinnon M. D.
19 ..... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hope Idaho — DATE OF BURIAL: Sept 19 1916

20. UNDERTAKER: E M Bonner — ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2153
(No. ....., ... St.)

File No. 15520
Registered No. 717

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonner

City of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thurman Shaffer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Aug 24 1 (Month) (Day) (Year)

7. AGE: 17 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Virginia

10. NAME OF FATHER Samuel Shaffer

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Rebecca Rutledge

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) [signature]
(Address) [illegible]

15. Filed Sept 22 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 22 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1916, to Sept-20 1916, that I last saw him alive on Sept-20 1916, and that death occured on the date stated above, at 1A M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm. A. Cramer M. D.

19..... (Address) Sandpoint -

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho — DATE OF BURIAL: Sept 23 1916

20. UNDERTAKER: Conner Brothers — ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15521

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Payette

Registration District No. 4

Primary Registration District No. 1008

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J. C. Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Not Known (Month) (Day) (Year)

7. AGE: 62 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming Labor

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J R Banks

(Address) Payette Idaho

15. Filed Sept 12 1916 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h— alive on ..... 191...,
and that death occured on the date stated above, at 7.30 A. M.

The CAUSE OF DEATH* was as follows:

Found dead. Autopsy showed enlarged heart, cirrhosis of liver, interstitial nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Woodward M. D.

1916 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: 9-12 1916

20. UNDERTAKER: Glenn C. Landon — ADDRESS: Payette Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BI...

BYMS - YORK CO., PTRS. & BORS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lalath
City of Kendrick
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No. 2143
(No. ....., ... St.)

File No. 15522
Registered No. 33
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Degner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH: Jan (Month) 30 (Day) 1852 (Year)

7. AGE: 64 yrs. 8 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Wm. Degner

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Wm Degner
(Address) Cameron Ida

15. Filed Sep 18 1916 J. E. Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sep (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 10 1916, to Sep 16 1916, that I last saw h. alive on Sep 16 1916, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
(Duration) One yrs. mos. ds.
Contributory (Secondary) Probably Stomach Ulcers
(Duration) 5 yrs. mos. ds.

(Signed) J W Stoneburner M. D.
Sep 18 1916 (Address) Leland Ida

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Manhato Minn
DATE OF ~~BURIAL~~ Removal: Sep 18 1916

20. UNDERTAKER: E. E. Bechtol
ADDRESS: Kendrick Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Southwick's. (No....., ...St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No. 2143

File No. 15523
Registered No. 32
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frances W Hottle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Widowed

6. DATE OF BIRTH: July (Month) 11 (Day) 1830 (Year)

7. AGE: 86 yrs. 2 mos. 11 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer): Retired farmer

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Aaron Hottle

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Hottle
(Address) Southwick's Ida

15. Filed Sep 23 1916 J. E. Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sep (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1916, to Sep 22 1916, that I last saw h[illegible] alive on Sep 10 1916, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Senility

(Duration) — yrs. 2 mos. — ds.

Contributory (Secondary): none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leo A Rothwell M. D.
10 23 1916 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Southwick's Ida
DATE OF BURIAL: Sep 24 1916

20. UNDERTAKER: none
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15525
Registered No. .....

1. PLACE OF DEATH.
County of Clearwater Registration District No. 91
City of Elk River (No. ....., ... St.) Primary Registration District No. 2168

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME not named

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH. Sept (Month) 15 (Day) 1916 (Year)
7. AGE ..... Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many 20 hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: c
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Elk River Idaho
10. NAME OF FATHER: Louis Young
11. BIRTHPLACE OF FATHER (State or Country): Massachusetts
12. MAIDEN NAME OF MOTHER: Edith Paine
13. BIRTHPLACE OF MOTHER (State or Country): South Dakota
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Young
(Address) ~~Dr Jno Dr M.D.~~ Elk River Idaho
15. Filed Sept. 16 1916 Mrs. J. Demen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 16 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1916, to Sept 16 1916, that I last saw her alive on Sept 16 1916 and that death occured on the date stated above, at 11:30 AM
The CAUSE OF DEATH* was as follows:
Premature birth at the 6½ month of Gestation.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Lack of nourishment
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) John Demen M. D.
19 .... (Address) Elk River Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elk River Idaho — DATE OF BURIAL ..... 191...
20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15526

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 91

County of Elmwater Primary Registration District No. 2168

City of Elk River Ida. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marko Radakovich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1873 (Year)

7. AGE

43 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Logger

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Austria

10. NAME OF FATHER Dmitar Radakovich

11. BIRTHPLACE OF FATHER (State or Country) Austria

12. MAIDEN NAME OF MOTHER Gjurka Obradovich

13. BIRTHPLACE OF MOTHER (State or Country) Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eli Kryvokuch

(Address) Elk River Ida.

15.

Filed July 16 1916 Mrs. J. Dennn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1916, to July 16 1916, that I last saw him alive on July 16 1916, and that death occured on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Contusion and rupture of left lung

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) John Dennn M. D.

19 (Address) Elk River, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elk River — DATE OF BURIAL: July 1[illegible] 1916

20. UNDERTAKER: C. J. Morris — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24953

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Canyon

Primary Registration District No. 8 0 0 7

City of Parma

(No. ....., ... St.)

File No. 15527

Registered No. [redacted] 17

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jack Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	S

6. DATE OF BIRTH: Dec (Month) 6 (Day) 1916 (Year)

7. AGE: yrs. 9 mos. 26 ds. IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canyon Co

10. NAME OF FATHER C. G. Hall

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Rose Dillon

13. BIRTHPLACE OF MOTHER (State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C G Hall
(Address) Parma Ida

15. Filed Oct 8 1916 Ida Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1916, to Oct 2 1916, that I last saw him alive on Oct 1 1916, and that death occurred on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(Duration) ..... yrs. ..... mos. 17 ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. B. Allen M. D.

Oct 3 1916 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Roswell — DATE OF BURIAL: Oct 3 1916

20. UNDERTAKER: Peckham Case Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15528

Registered No. 27

1. PLACE OF DEATH.

County of Canyon

City of Parma

Registration District No. 3

Primary Registration District No. 2007

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ira Ruth Ross

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	S

6. DATE OF BIRTH: Feb (Month) 9 (Day) 1915 (Year)

7. AGE: 1 yrs. 7 mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canyon Co Ida

10. NAME OF FATHER Wm H Ross

11. BIRTHPLACE OF FATHER (State or Country) Ida

12. MAIDEN NAME OF MOTHER Maggie Harris

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M T Ross
(Address) Parma Ida

15.
Filed Oct 6 1916 Lulu Waldrop
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 26 1916, to Oct. 3 1916, that I last saw her alive on Oct. 3 1916, and that death occurred on the date stated above, at 10-30 A.M.

The CAUSE OF DEATH* was as follows:
Whooping Cough
(Duration) — yrs. — mos. 7 ds.
Contributory Convulsions
(Secondary)
(Duration) — yrs. — mos. 7 ds.

(Signed) W. E. Mulard M. D.
Oct. 6 1916 (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Parma Cem DATE OF BURIAL Oct 5 1916

20. UNDERTAKER Peckham Coffin Co ADDRESS Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Canyon

Primary Registration District No. 2007

File No. 15530

City of Parma

(No. ....., ... St.)

Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samantha Christina Wymer.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	

6. DATE OF BIRTH: July (Month) 16 (Day) 1849 (Year)

7. AGE: 67 yrs. 2 mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Hulse

11. BIRTHPLACE OF FATHER (State or Country): Do not Know

12. MAIDEN NAME OF MOTHER: Do not Know

13. BIRTHPLACE OF MOTHER (State or Country): Do not Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E V Upper
(Address)

15.
Filed Sep 24 1916 Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: September (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 16 1916, to Sept 23 1916, that I last saw h-r alive on Sept. 22 1916, and that death occurred on the date stated above, at 7-10 A.M.

The CAUSE OF DEATH* was as follows:
Infection of Gall Bladder

(Duration) — yrs. about 7 mos. — ds.
Contributory (Secondary) General debility

(Duration) — yrs. — mos. — ds.

(Signed) W. E. Hulse M. D.
Sept. 24 1916 (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Parma — DATE OF BURIAL: Sept 24 1916

20. UNDERTAKER: Peckham [illegible] — ADDRESS: Parma

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Teton
City of Clawson
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 77
Primary Registration District No. 2176
(No. ..... St.)

File No. 15531
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella May Fullmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant.
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Clawson, Ida.

10. NAME OF FATHER H. D. Fullmer

11. BIRTHPLACE OF FATHER (State or Country) Salt Lake City, Utah.

12. MAIDEN NAME OF MOTHER Lidia Alvina Nash

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15.
Filed 8 — 10 1916 C Cherrington
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug. (Month) 8th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

No Doctor in attendance

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Clawson	8 9 1916
20. UNDERTAKER Absent	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Teton
City of Driggs
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 77
Primary Registration District No. 2176
(No. ....., ... St.)

File No. 15532
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 22 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.? 4

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Leonard Andrews

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lucy Wood

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lucy Woods
(Address) Bates, Ida.

15.
Filed 9-25 1916 C. Cherrington Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4 P.M. Sept 20 1916 to 8 P.M. Sept 22 1916 that I last saw h.. alive on Sept 22 1916 and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth
.....
.....
(Duration) 4 hours yrs. mos. ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas J Martin M. D.
Sept 22 1916 (Address) Driggs, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Teton | DATE OF BURIAL: 9-23 1916

20. UNDERTAKER: Teton | ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15533

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lemhi

City of Briggs

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 77

Primary Registration District No. 2176

(No. ....., ... St.)

2. FULL NAME Thomas Garlic

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 6 (Month) 24 (Day) 1915 (Year)

7. AGE: 1 Yrs. 1 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Briggs Lemhi Co. Ida

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Bessie Garlic

13. BIRTHPLACE OF MOTHER (State or Country) Mt Pleasant Ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward Garlic
(Address) Briggs Idaho

15. Filed 8-10 1916 C. Cherrington Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-2 1916, to 8-3 1916, that I last saw him alive on 8-2 1916, and that death occured on the date stated above, at 4. a M.

The CAUSE OF DEATH* was as follows:
Enteritis.

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Malnutrition.

(Duration 1 yrs. ..... mos. ..... ds.

(Signed) Ben F. Roseman M. D.

8-3 1916 (Address) Briggs Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt Pleasant — DATE OF BURIAL: 8-4 1916

20. UNDERTAKER Ford — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17
Primary Registration District No. 2176
File No. 15534
Registered No. .....

1. PLACE OF DEATH.
County of Lehi
City of Lehiria
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jessie Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 2 (Month) 2 (Day) 1900 (Year)

7. AGE: 16 Yrs. 7 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): + Smithfield Utah

10. NAME OF FATHER: + Heber John Thompson

11. BIRTHPLACE OF FATHER (State or Country): + Salt Lake City - Utah

12. MAIDEN NAME OF MOTHER: + Sylvia M Woodruff

13. BIRTHPLACE OF MOTHER (State or Country): + Salt Lake City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Heber John Thompson
(Address) Lehiria Idaho

15.
Filed 8-10 1916 C Cherrington Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
8 (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-4 1916, to 8-4 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 4302 M.

The CAUSE OF DEATH* was as follows:
Struck by lightning.
While haying in field.
Near his home.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ben. L. Rogerson M. D.
8-5 1916 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: + Haden Cemetary — DATE OF BURIAL: + Aug 7 1916

20. UNDERTAKER: + J A Blair — ADDRESS: + Tetonia Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15536

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of Twin Falls

Registration District No. 27

Primary Registration District No. 1085

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME No Name

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept (Month) 27 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miscarriage

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. E. Timmons

11. BIRTHPLACE OF FATHER (State or Country): Me.

12. MAIDEN NAME OF MOTHER: Olive Ryan

13. BIRTHPLACE OF MOTHER (State or Country): Me.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. E. Timmons

(Address) Twin Falls R.D.

15. Filed 9 27 1916

John F. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1916, to Sept 26 1916, that I last saw h[illegible] alive on June [illegible] 1916, and that death occured on the date stated above, at 3:30 M.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Duncan L Alexander M. D.

9/26 1916 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 9-27 1916

20. UNDERTAKER: C J Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

Koochuck

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15537

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of Burger

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 2085

(No. ....., ..., St.)

2. FULL NAME Henry C. Morree

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mak

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March 10 (Month) 1868 (Day) (Year)

7. AGE: 48 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Caben Morree

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Lydia Dove

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. D. Morrill

(Address) Emberly Idaho

15. Filed 9-6 1916 John F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 7th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1916, to Sept 7, 1916, that I last saw him alive on Aug 26, 1916, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Sarcoma of arm.

about 1 year.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Coudek M. D.

Sept 7, 1916. (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~, OR REMOVAL: Twin Falls

DATE OF BURIAL: 9-8 1916

20. UNDERTAKER: Crosby

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 37

Primary Registration District No. 1085

File No. 15538

County of Twin Falls

City of .....

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wayne Carver Hoskins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 14 (Day) 1895 (Year)

7. AGE: 21 Yrs. 5 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Morrow Co. Oregon

10. NAME OF FATHER: Thomas Hoskins

11. BIRTHPLACE OF FATHER (State or Country): Wayne Co. Iowa.

12. MAIDEN NAME OF MOTHER: Mary Hoskins

13. BIRTHPLACE OF MOTHER (State or Country): Linn Co Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Mr & Mrs Thomas Hoskins

(Address): Hansen Idaho

15.

Filed 9 13 1916 Dr. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16, 1916, to Sept 11, 1916, that I last saw him alive on Sept 11, 1916, and that death occured on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis.

About 4

(Duration) ..... Yrs. 9 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Loudyk M. D.

Sept 11 1916 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls

DATE OF BURIAL: 9-13 1916

20. UNDERTAKER: E J Crosby

ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24053

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37.
Primary Registration District No. 1085
File No. 15539
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kagno Shigeta

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Japanese
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 10 (Day) 1914 (Year)

7. AGE: 2 Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Prop. Rooming House
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A. Shigeta

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: T. Fujii

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. Shigeta
(Address) Twin Falls Idaho

15.
Filed 9 14 1916 Dr Coulter
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1916, to Sept 12 1916, that I last saw h.. alive on Sept 12 1916 and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Jno Coburn M. D.
Sept 12 1916. (Address) 703 Main Ave. N.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Sept 14 1916

20. UNDERTAKER: Grossman & Evans — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls — Registration District No. 37
City of " " — Primary Registration District No. 1085 — (No. ....., ... St.)
File No. 15540
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elliott Cammaron Black

If death occurred in a hospital, institution or camp, state NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Aug (Month) 5th (Day) 1903 (Year)

7. AGE: 13 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Twin Falls

10. NAME OF FATHER Leroy Black

11. BIRTHPLACE OF FATHER (State or Country) Amherst Nova Scotia

12. MAIDEN NAME OF MOTHER Mildred Cammaron

13. BIRTHPLACE OF MOTHER (State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Lidyard Perrine
(Address) Twin Falls Idaho.

15.
Filed Sep 12. 1916 Dr Coughlin
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
9 (Month) — 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-1 1916, to 9-8 1916,
that I last saw h[illegible] alive on 9-8 1916,
and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
T B Meningitis

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Pneumonia
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. F. Alexander M. D.
9-8 1916 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~ Twin Falls — DATE OF BURIAL 9-9 1916

20. UNDERTAKER C J Crosby — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15541

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of Twin Falls

(No. ....., ... St.)

Registration District No. 37

Primary Registration District No. 1085

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Sybilla Bilger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Married~~

6. DATE OF BIRTH. Nov. 16, 1868 (Month) (Day) (Year)

7. AGE: 68 Yrs. 19 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Fredoline Trimp

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Jacob Bilger

(Address) Heyburn Ida

15. Filed 9 6 1916 John F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 6th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10th 1916, to Sept 6 1916, that I last saw her alive on Sept 5 1916, and that death occured on the date stated above, at 3:00 A. M.

The CAUSE OF DEATH* was as follows:

Sub Phrenic Abscess

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Chronic cystitis

..... (Duration 2 yrs. ..... mos. ..... ds.

(Signed) J.O. Boyd M. D.

Sept 6 1916 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Heyburn DATE OF BURIAL 191

20. UNDERTAKER: D. J. Crosby ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BMRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15542

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of " "

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. ....., ... St.)

2. FULL NAME Edward C Carlson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (write the word): Married

6. DATE OF BIRTH. Dec. 26 (Month) (Day) 1881 (Year)

7. AGE: 34 Yrs. 8 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Nebr.

10. NAME OF FATHER J. W. Carlson

11. BIRTHPLACE OF FATHER (State or Country) Swedeland

12. MAIDEN NAME OF MOTHER Marie Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arthur A Carlson
(Address) Twin Falls

15.
Filed 9 22 1916 John F Peavey Jr
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 16 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1915, to Sept 16 1916, that I last saw him alive on Sept 16 1916 and that death occured on the date stated above, at 9.30 P M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 10 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Allen E White M. D.

19.... (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Twin Falls — DATE OF BURIAL: 9-19 1916

20. UNDERTAKER: Thos J. Crosby — ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of ...
Registration District No. 37
Primary Registration District No. 1085
(No. ..., ... St.)
File No. 15543
Registered No. ...

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph A Abramson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married
6. DATE OF BIRTH. June (Month) 10 (Day) 1878 (Year)
7. AGE: 38 Yrs. 7 Mos. 9 ds.
IF LESS than 1 day how many ...hrs. or ...min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): ...
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: John Abramson
11. BIRTHPLACE OF FATHER (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Cristena Johnson
13. BIRTHPLACE OF MOTHER (State or Country): Sweden
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) ...
(Address) Sam Abramson
15. Filed 9 22 1916 John F Corbaley
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
9 (Month) — 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 191..., to ... 191..., that I last saw h... alive on ... 191..., and that death occured on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart. Small white Kidneys.

(Duration) unknown yrs. ... mos. ... ds.

Contributory (Secondary) ...
(Duration ... yrs. ... mos. ... ds.

(Signed) John F. Coughlin M. D.
9-22 1916 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Sunset Memorial
DATE OF BURIAL: Sept. 22 1916
20. UNDERTAKER: Twin Falls Cemetery
ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15544

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Twin Falls

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No 37

Primary Registration District No 1085

2. FULL NAME Fred P. Tilton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 1 (Day) 1858 (Year)

7. AGE: 58 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mass

10. NAME OF FATHER: Jas Tilton

11. BIRTHPLACE OF FATHER (State or Country): Mass

12. MAIDEN NAME OF MOTHER: Hogan

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. F. Tilton

(Address) .....

15. Filed 9 22 1916 John F. Coughlin Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) - 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 26 1916, to Sept. 22 1916, that I last saw h[illegible] alive on Sept. 22 1916, and that death occured on the date stated above, at 12-A M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Weaver M. D.

19 ..... (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ REMOVAL: Chicago Ill

DATE OF BURIAL: 9-2X 1916

20. UNDERTAKER: [illegible] Co by

ADDRESS: 94

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. Alexander

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15545

Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. ....., ... St.)
Registration District No. 37.
Primary Registration District No. 1085

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jas. Franklin Bauer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced
6. DATE OF BIRTH. Sept 14 (Month) (Day) 1837 (Year)
7. AGE: 79 Yrs. X Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Tenn
10. NAME OF FATHER: Chas. Bauer
11. BIRTHPLACE OF FATHER (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Salome Miller
13. BIRTHPLACE OF MOTHER (State or Country): Penn
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. F. Bauer
(Address) Filer R.D. # 2.
15. Filed 9. 21 1916. John F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 19th 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov. 15 1916, to Sept 19 1916, that I last saw him alive on Sept 19 1916, and that death occured on the date stated above, at 7 A M.
The CAUSE OF DEATH* was as follows:
Incompensation of Mitral and aortic regurgitation
(Duration) 10 Yrs. mos. ds.
Contributory (Secondary) Chronic Bright's Interstitial arteriosclerosis —
(Duration ? yrs. mos. ds.
(Signed) Duncan Lytle & under M. D.
9/21 1916 (Address) Twin Falls —

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Ida. DATE OF BURIAL: 9-20 1916
20. UNDERTAKER: Chas J Crosby ADDRESS: T.F.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls — Registration District No. 37 — Primary Registration District No. 10 85 — File No. 15546

City of ..... (No. ....., ... St.) — Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louie A. Kiersted

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov (Month) 28 (Day) 1908 (Year)

7. AGE: 7 Yrs. 9 Mos. 24 ds. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer): /

9. BIRTHPLACE (State or Country): Twin Falls

10. NAME OF FATHER: L. D. Kiersted

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Julia Wood

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. Kiersted
(Address) .....

15. Filed 9 22 1916 — John F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1916, to Sept 21 1916, that I last saw h[im] alive on Sept 21 1916, and that death occured on the date stated above, at 5 p M.

The CAUSE OF DEATH* was as follows:

Tuberculer Meningetis

(Duration) Yrs. mos. 28 ds.

Contributory (Secondary) Tuberculosis of Left Lung

(Duration yrs. 2 mos. 6 ds.

(Signed) Duncan L Alexander M. D.

9/22 1916 (Address) 116 1/2 Main St N

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls Ida	9 22 1916
20. UNDERTAKER	ADDRESS
E J Crosby	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BSRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 15547
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of .....
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nova Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. January 12 (Month) (Day) 1907 (Year)

7. AGE: 9 Yrs. 8 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Albert Lee

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Lulu Swilliger

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert Lee
(Address) Twin Falls

15. Filed 9 28 1916 John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 27 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1916, to Sept 27" 1916, that I last saw her alive on Sept 26 1916, and that death occured on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) Not known Yrs. mos. ds.

Contributory (Secondary) Peritonitis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Sept 28 1916 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filer — DATE OF BURIAL: Sept 28 1916

20. UNDERTAKER: Grosman & Evans — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15548
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .. .. ..
Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Burtrum Gordon Heath

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. 27 March 27 1902
(Month) (Day) (Year)

7. AGE 14 Yrs. 6 Mos. 12 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION School Student
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) almo Cassia Co Ida

10. NAME OF FATHER G Gr Heath

11. BIRTHPLACE OF FATHER (State or Country) Plain City Utah

12. MAIDEN NAME OF MOTHER Emma Edwards

13. BIRTHPLACE OF MOTHER (State or Country) Willard Boxelder Co Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G Gr Heath
(Address) Rasmussen Ida

15. Filed 9 16 1916 John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 6 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-13-1916, to 9-15-1916, that I last saw h in alive on 9-14-1916, and that death occured on the date stated above, at 2 PM.

The CAUSE OF DEATH* was as follows:

Cholemia due to
Cholangitis
(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John R Morgan M. D.
9-16 1916 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL, REMOVAL: Twin Falls — DATE OF BURIAL: 9-17 1916

20. UNDERTAKER: C Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15549

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

2. FULL NAME Jack Irwin Calkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 14 (Day) 1916 (Year)

7. AGE ..... Yrs. 5 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... Electrician

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Harry Calkins

11. BIRTHPLACE OF FATHER (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Clara Carr

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. L. Calkins

(Address) Twin Falls

15. Filed 10 16 1916 John F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from " 191..., to " 191..., that I last saw h" alive on " 191..., and that death occured on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Stomach
causing heart failure

(Duration) Found dead in crib hrs. mos. ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John R Morgan M. D.

10-6-1916 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Sept 29 1916

20. UNDERTAKER: Brannan & Eames — ADDRESS: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STRS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2001
Primary Registration District No. 9
File No. 15552
Registered No. 86

1. PLACE OF DEATH.
County of Ada
City of Star
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leonel Leonon
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: July 30 (Month) 27 (Day) 1916 (Year)

7. AGE: ..... yrs. 1 mos. 27 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Middleton,

10. NAME OF FATHER: Chester D Corren.

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ellen Bass

13. BIRTHPLACE OF MOTHER (State or Country): My

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chester Corren
(Address) Star Idaho

15. Filed Sept 26 1916 Overstreet. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. 26, 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21 1916, to Sept 25 1916, that I last saw h[illegible] alive on Sept 25 1916, and that death occurred on the date stated above, at 6 M.

The CAUSE OF DEATH* was as follows:
Entero Colitis.

(Duration) ..... yrs. 1 mos. 3 ds.
Contributory (Secondary) Tuberculosis Meningitis
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) O Overstreet M. D.
9/26 1916 (Address) Star, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Star Cemetary | DATE OF BURIAL: 9-27 1916

20. UNDERTAKER: Ivy T Summers | ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7011

File No. 15553

County of Ada

Primary Registration District No.

Registered No. 31

City of

(No. 3 mi N.E. of Star St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George W. McIntyre

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (If married, widowed or divorced, write the word.): Married

6. DATE OF BIRTH. Sept (Month) 27 (Day) 1853 (Year)

7. AGE: 63 Yrs. 10 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: Alexander Mc Intyre

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Mary J Morden

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs D. C. Byers
(Address) Caldwell Idaho

15. Filed Aug 21 1916 O.W. Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1916, to Aug 20 1916, that I last saw h alive on Aug 20 1916, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Mitral stenosis with heart block
(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) M. H. Hallinan M. D.
19 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery. DATE OF BURIAL: Aug 21 1916

20. UNDERTAKER: Grey & Cummens ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15554

Registered No.

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

County of Ada

City of Star (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel McDowell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. ~~DATE OF BIRTH~~ Died Aug 9 1916

1837 (Month) July (Day) 23 (Year)

7. AGE: 79 yrs. 7 mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles McDowell
(Address) Star Idaho

15.
Filed ..... 191 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 1916, to Aug 1916
that I last saw him alive on Aug 9 1916
and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) 1 hour yrs. 4 mos. ds.
Contributory (Secondary) Old age
(Duration) yrs. mos. ds.

(Signed) Chas Hall M. D.
8/10 1916 (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery | DATE OF BURIAL: Aug 10 1916

20. UNDERTAKER: Hagerman & Hall | ADDRESS: Nampa Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Ferdun
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 7168
(No. ....., ... St.),

File No. 15555
Registered No. 48
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Virginia C. Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1873 (Year)

7. AGE: 43 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Olsen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Frederickson
(Address) Lenore, Ida

15. Filed Oct 1 1916 J. M. Fairley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 30 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1916, to Sept 30 1916, that I last saw h[illegible] alive on Sept 30 1916, and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Shock following difficult labor and version

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. McCarthy M. D.

Sept 30 1916 (Address) Orofino, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kenn, Ida — DATE OF BURIAL: Oct 2 1916

20. UNDERTAKER: W. E. Stoddard — ADDRESS: Lapwai Ida

BYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-15 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15556

Registered No. 45

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Clearwater

City of Orofino, Ida

(No. ....., ... St.)

Registration District No. 90

Primary Registration District No. 2168

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jane Woodford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. (Month) (Day) 1843 (Year)

7. AGE: 73 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): —

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. B. Clanton

(Address) Orofino Ida

15.

Filed ..... 191.....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22 1910, to Sep 7 1916, that I last saw her alive on Sep 6 1916, and that death occured on the date stated above, at 9:50 A.M.

The CAUSE OF DEATH was as follows:

Cancer

(Duration) 24 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

(Duration 24 yrs. — mos. — ds.

(Signed) John Clements M. D.

Sept. 7 1916 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. 6 yrs. 6 mos. 16 days. In the State. ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence N. I. Sanitarium

19. PLACE OF BURIAL OR REMOVAL: Sanitarium Cemetery — DATE OF BURIAL: Sep 9 1916

20. UNDERTAKER: P. M. Johnson — ADDRESS: Orofino, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMB - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15557
Registered No. 505

1. PLACE OF DEATH.
County of Kootenai
City of Post Falls

Registration District No. 20
Primary Registration District No. 2057
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Female baby

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 26 (Day) 1916 (Year) (12 P.M.)

7. AGE: ___ yrs. ___ mos. ~~1 ds.~~ ds. IF LESS than 1 day how many 8 hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rural Post Falls, Ida.

10. NAME OF FATHER: Bert. B. Bowman

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Minnie May Hale

13. BIRTHPLACE OF MOTHER (State or Country): Garfield Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B.F. Campbell M.D.
(Address) Post Falls, Ida

15.
Filed July 10 1916 A.D. Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 26th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26 - 1 P.M. 1916, to July 26 3 P.M. 1916
that I last saw h[illegible] alive on July 26th 1916
and that death occurred on the date stated above, at 7.30 P. M.

The CAUSE OF DEATH* was as follows:
Premature birth.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B.F. Campbell M. D.
July 27 1916 (Address) Post Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cemetery
DATE OF BURIAL: July 27 1916

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS. BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 20

County of Kootenai

Primary Registration District No. 2051

File No. 15559

City of Twin Lakes, Idaho (No. Twin Lakes, Idaho St.)

Registered No. 504

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Frances Blackmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
fem.	white	widowed

6. DATE OF BIRTH: Oct. 1863 1 (Month) (Day) (Year)

7. AGE: 52 yrs. 8 mos. ds. IF LESS than 1 day how many.....*hrs. or* .....*mins.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: George Dillard

11. BIRTHPLACE OF FATHER (State or Country): Indianis

12. MAIDEN NAME OF MOTHER: unobtainable

13. BIRTHPLACE OF MOTHER (State or Country): Unobtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bessie Hoffine
(Address) 2418 W Glass ave

15. Filed Sept 10 1916 A O Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. 1, 1916 7:50 PM
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1916, to Aug 1 1916, that I last saw her alive on Aug 1 1916, and that death occurred on the date stated above, at 7:50 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

(Duration) yrs. mos. ds.

Contributory (Secondary) Arterio sclerosis (?)

(Duration) yrs. mos. ds.

(Signed) Arthur C Johnson M. D.

8/2 1916. (Address) Spokane Wn.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence 2418 W Glass ave Spokane, Wn

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Incineration	Aug. 3 1916

20. UNDERTAKER	ADDRESS
Smith & Co	11 & N Riverside

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Post Falls

Registration District No. 20
Primary Registration District No. 2051
(No. ....., ... St.)

File No. 15560
Registered No. 87

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Floyd W. Manor

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: December (Month) 19 (Day) 1896 (Year)

7. AGE: 19 yrs. 8 mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wilmot S. Dakota

10. NAME OF FATHER: Anthony J. Manor

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Mary Baker

13. BIRTHPLACE OF MOTHER (State or Country): Eu Claire Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [redacted] G. Manor
(Address) Post Falls Idaho

15.
Filed Sept 6 1916 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1916., to Aug - 19 1916., that I last saw h[illegible] alive on July 4th 1916 and that death occurred on the date stated above, at 2.9 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis Acute

..... (Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B.F. Campbell M. D.

(Aug 19 1916. (Address) Post-Falls.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Post Falls Ida — DATE OF BURIAL: Aug 20 1916

20. UNDERTAKER: S J Luce — ADDRESS: Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Hauser
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 20
Primary Registration District No. 2051
(No. ....., ... St.)

File No. 15561
Registered No. 509
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Freeman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 13 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Clarence E. Freeman

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Alice Smith

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence E. Freeman
(Address) Hauser Idaho.

15.
Filed 9/10 1916 D. W. Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 28th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 2:00 a. M.

The CAUSE OF DEATH* was as follows:
The Parents refused
Medical attendance. The last
Two Days. Dr. had Attention Early
Requested (Duration) Time it operated ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Diphtheria Developed as
a Complication of Some
Family (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Frank Wenz M. D.
8/28 1916 (Address) Hauser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: [redacted] DATE OF BURIAL: Aug 28 1916

20. UNDERTAKER: C. W. Stone ADDRESS: Rathdrum Ida

BYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 20
Primary Registration District No. 2089
File No. 15562
Registered No. 108

1. PLACE OF DEATH.
County of Kootenai
City of Hauser
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Estha Elizabeth Freeman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Septbr. 7. (Month) (Day) 1906 (Year)

7. AGE: 9 yrs. 11 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Clarence E. Freeman

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Alice Smith

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence E. Freeman
(Address) Hauser Idaho

15. Filed Sept 10 1916 D D Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 27. 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 10. 1916, to August 27. 1916
that I last saw h[er] alive on August 20. 1916.
and that death occurred on the date stated above, at 2 30 P. M.

The CAUSE OF DEATH* was as follows:
Diphtheria

(Duration) ..... yrs. ..... mos. 20 ds.
Contributory (Secondary) Post Diphtheritic paralysis.
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Frank Wing M. D.
8/28 1916 (Address) Rathdrum Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Post Falls — DATE OF BURIAL: Aug 28 1916

20. UNDERTAKER: A. W. Stone — ADDRESS: Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 20

Primary Registration District No. 2051

File No. 15563

County of Kootenai

City of Rathdrum (No. ....., ... St.)

Registered No. 507

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pearl Freeman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	single

6. DATE OF BIRTH: Sept 6 (Month) 7 (Day) 1907 (Year)

7. AGE: 8 yrs. 11 mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kootenai County - Ida.

10. NAME OF FATHER: Clarence E. Freeman

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Alice Nobles

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence E. Freeman
(Address) .....

15. Filed Sept 10 1916 — J. D. Brennen, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 15. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 10. 1916, to Aug. 15. 1916, that I last saw her alive on Aug. 15. 1916, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) Heart Failure

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Frank Perry M. D.

8/16. 1916. (Address) Rathdrum, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Post Falls — DATE OF BURIAL: Aug 16 191..

20. UNDERTAKER: O. W. Stone — ADDRESS: Rathdrum

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Athol
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 20
Primary Registration District No. 2051
(No. ....., ... St.)

File No. 15564
Registered No. 506
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nancy J. Douglas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: Jan (Month) 18 (Day) 1848 (Year)

7. AGE: 68 yrs. 7 mos. 7 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: — Struckin

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. W. Douglas
(Address) Athol Ida

15. Filed Sept 10 1916 D D Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 25. (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 19 1915, to August 25. 1916, that I last saw h[illegible] alive on July 30. 1916, and that death occurred on the date stated above, at 5. P M.

The CAUSE OF DEATH* was as follows:
Chronic rheumatism
(Duration) 3 yrs. mos. ds.
Contributory (Secondary) Arterio Sclerosis
(Duration) 3 yrs. mos. ds.

(Signed) Frank W Pfau M. D.
8/26 1916. (Address) Rathdrum Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Athol Idaho | DATE OF BURIAL: Aug 27 1916

20. UNDERTAKER: A. W. Stone | ADDRESS: Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Rathdrum

Registration District No. 20

Primary Registration District No. 2057

(No. ....., ... St.)

File No. 15565

Registered No. 172

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo H Waddell

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~. (Write the word.): Single

6. DATE OF BIRTH: Sep (Month) 13 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Father's occupation
(b) General nature of industry business, or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Ramsey Idaho

10. NAME OF FATHER: Henry A Waddell

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Verna Davis

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry A Waddell
(Address) .....

15. Filed 10/10 1916 D D Beaman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sep (Month) 22. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 13. 1916 to Sep. 22. 1916 that I last saw h[e] alive on Sep. 21. 1916 and that death occurred on the date stated above, at 12 15 M.

The CAUSE OF DEATH* was as follows:
Congenital weakness and acute indigestion

(Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary): None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Wing M. D.

9/22 1916 (Address) Rathdrum, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Idea | DATE OF BURIAL: Sep 22 1916

20. UNDERTAKER: O. W. Stein | ADDRESS: Rathdrum Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 20
Primary Registration District No. 2051
File No. 15566
Registered No. 510

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum
(No. Maggie S. Cunningham Street)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME ~~Margaret~~

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: March (Month) (Day) 1845 (Year)

7. AGE: 60 yrs. 5 mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hause wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: J M Snodgrass

11. BIRTHPLACE OF FATHER (State or Country): Pan

12. MAIDEN NAME OF MOTHER: — Spence

13. BIRTHPLACE OF MOTHER (State or Country): Pen

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Cunningham
(Address) Rathdrum

15.
Filed 9/10 1916 D D Dennard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Sep 1st 8 A.M. 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1. 1916, to Sept 1 1916, that I last saw h. sw alive on Apr 25 1916, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Vagina

(Duration) yrs. 7 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D D Dennard M. D.

9/11 1916 (Address) Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Ida
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: O W. Stone
ADDRESS: Rathdrum Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7 15567

Registered No. 13

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D Alene

Registration District No. 29

Primary Registration District No. 1058

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jean C Caldwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 23 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Wm Carson

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Jennie Shulenburger

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Orval Caldwell

15. Filed Oct 6 1916 — D D Dreman, Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 5 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 27 1916, to Oct. 5 1916, that I last saw her alive on Oct. 3 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Frances G. Stewart M. D.

10-6 1916 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dayton Wash — DATE OF BURIAL: 1916

20. UNDERTAKER: J J Lewis — ADDRESS: C 19 9

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7 15568

Registered No. 14

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D'Alene

Registration District No. 29

Primary Registration District No. 1050

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles F Igo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Apr. (Month) 7 (Day) 1847 (Year)

7. AGE: 69 Yrs. 5 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Igo

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Eliza Hall

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs A. Goldthorn

(Address) .....

15. Filed Oct 16 1916 — A. Hughes, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 6 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ ..... 191..., to ..... 191...,

that ~~I last saw h~~ alive on ..... 191...,

and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 2 Yrs. ~ mos. ~ ds.

Contributory (Secondary) .....

(Duration ~ yrs. ~ mos. ~ ds.

(Signed) W. H. Holden M. D.

10/16 1916 (Address) Coeur d Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Oct. 11 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24659

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

File No. 15569
Registered No. 15

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d Alene
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Archibald Mullen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH.
May (Month) 3 (Day) 1834 (Year)

7. AGE
82 Yrs. 5 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Canada

10. NAME OF FATHER: John Mullen

11. BIRTHPLACE OF FATHER
(State or Country) Scotland

12. MAIDEN NAME OF MOTHER: Eliza Cunning

13. BIRTHPLACE OF MOTHER
(State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. A. Mullen
(Address) Coeur d'Alene

15.
Filed Oct-6 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1916, to Oct 4 1916, that I last saw h. alive on Oct 4 1916, and that death occured on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Brights Disease
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Arterio Sclerosis
(Duration) ... yrs. ... mos. ... ds.
(Signed) J. A. Holden M. D.
10/6 1916 (Address) Coeur d Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	Oct 8 1916
20. UNDERTAKER	ADDRESS
T. C. Hodel	C. D. A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15570

Registered No. 16

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 1055

County of Kootenai

City of Coeur D'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elisabeth Basler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Sept. (Month) 29 (Day) 184[illegible] (Year)

7. AGE: 75 Yrs. 11 Mos. ..... ds. 22

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Switzerland

10. NAME OF FATHER Leutwyler

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Tannebaker

(Address) .....

15. Filed Sept-24 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep. (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep. [illegible] 1916, to Sep. 21 1916, that I last saw h[illegible] alive on Sep 21 1916 and that death occured on the date stated above, at 9. P M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

Senera[illegible]

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic intestinal nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John O Wood M. D.

Sep 23 1916 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Sept 24 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 29
Primary Registration District No. 1050
(No. ..... St.)

File No. 15571
Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Shramick

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
December 11th 1898
(Month) (Day) (Year)

7. AGE
18 Yrs. 9 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER John Shramick

11. BIRTHPLACE OF FATHER (State or Country) Bohemian

12. MAIDEN NAME OF MOTHER Anna Wolf

13. BIRTHPLACE OF MOTHER (State or Country) Bohemian

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Shramick
(Address) Coeur d'Alene

15.
Filed Sept 16 191[illegible]
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept 14 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Sept. 11 1916,
that I last saw h[illegible] alive on Sept 11 1916,
and that death occured on the date stated above, at 11 A. M.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ..... Yrs. 9 mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Byers M. D.
Sept 16 1916 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: M. Thomas Cemetery
DATE OF BURIAL: [illegible] 6. 1916

20. UNDERTAKER: T. E. Hudak
ADDRESS: C. D. A.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15572

Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29

Primary Registration District No. 1050

2. FULL NAME Lorena Dot Carver

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 2 (Day) 1878 (Year)

7. AGE 38 Yrs. 7 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Chas. Hatch

11. BIRTHPLACE OF FATHER (State or Country): New Hampshire

12. MAIDEN NAME OF MOTHER: Huldah

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. C. Carver

(Address) Coeur d'Alene Idaho

15.

Filed Sept. 27 1916

O. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep. (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep. 18. 1916, to Sep. 26 1916, that I last saw h Ex alive on Sep 26 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pelvic peritonitis.

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John D Wood M. D.

Sep 27 1916 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Sept 28 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15573

Registered No. 48

1. PLACE OF DEATH. Registration District No. 24

County of Kootenai Primary Registration District No. 1050

City of Coeur d'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm [illegible]

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Divorced

6. DATE OF BIRTH: ~~Dec~~ Sept 18 (Month) (Day) [illegible] (Year)

7. AGE: 65 yrs. ✓ mos. ✓ ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sr. Wauteny Ann
(Address) Coeur d'Alene

15. Filed Sept 21 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 18 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1916., to Sept 18 1916 that I last saw him alive on Sept 17, 16 1916 and that death occurred on the date stated above, at ..... M. The CAUSE OF DEATH* was as follows: between the hours of 7-950 pm 17-850 am 17th

Heart Failure

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Subacute Inflamation of Joints

..... (Duration) ..... yrs. mos. 10 ds.

(Signed) C E Wynkoop M. D.

..... 19..... (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 11/12 ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence Hot Springs Ark.

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Sept 21 1916

20. UNDERTAKER: [illegible] — ADDRESS: C.D.A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-26 M. 1-16-18

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17
Primary Registration District No. 2196
File No. 15574
Registered No. 134

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Genevieve McClendon.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. (Month) 9 (Day) 1916 (Year)

7. AGE: 0 Yrs. 7 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley. Ida.

10. NAME OF FATHER: Seburn McClendon.

11. BIRTHPLACE OF FATHER (State or Country): Texas.

12. MAIDEN NAME OF MOTHER: Viviard (Vivie) McClendon

13. BIRTHPLACE OF MOTHER (State or Country): Colorado.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S. M. McClendon
(Address) Burley Ida.

15. Filed Sept. 25th 1916. Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/1 – 1916, to 9/24 1916, that I last saw h er alive on 9/24 – 1916, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
= Hereditary Syphilis =

(Duration) Yrs. 7 mos. 15 ds.

Contributory (Secondary)
(Duration — yrs. — mos. — ds.

(Signed) C. W. Cooper M. D.
19..... (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Sept 26 1916

20. UNDERTAKER: C. Gallagher ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24058

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 117

Primary Registration District No. 21 96

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15575

Registered No. 132

1. PLACE OF DEATH.

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Nichols

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) (Day) 1916. (Year)

7. AGE: 1 Yrs. 3 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Ida.

10. NAME OF FATHER: Harry Nichols.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Orella M. Bateman.

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Nichols

(Address) Burley Ida.

15. Filed Sept. 11th 1916 — W. J. C. Patterson, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) — 10 (Day) — 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/7 — 1916, to 9/10 — 1916, that I last saw h. mi alive on 9/9 — 1916, and that death occured on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(Duration) — Yrs. — mos. 8 — ds.

Contributory (Secondary) —

(Duration — yrs. — mos. — ds.

(Signed) L. H. Cooper M. D.

9/8 1916 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley. Ida. DATE OF BURIAL: Sept 12 1916

20. UNDERTAKER: O'Gallogly. ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196.
File No. 15576
Registered No. 130

1. PLACE OF DEATH.
County of Cassia
City of Burley.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis E. Price.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Sept (Month) 20 (Day) 1914 (Year)

7. AGE
2 Yrs. ..... Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Bannock Co. Ida.

10. NAME OF FATHER
Will J. Price.

11. BIRTHPLACE OF FATHER
(State or Country) Logan Utah.

12. MAIDEN NAME OF MOTHER
Sarah Hutchison

13. BIRTHPLACE OF MOTHER
(State or Country) San Pete Co. Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Will J Price
(Address) Burley Idaho.

15.
Filed Sept. 25th 1916.
Dr. J. C. Patterson
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept. (Month) 25th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 21st 1916, to Sept. 25th 1916, that I last saw him alive on Sept. 25th 1916, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Pleu. Colitis

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
10-25 1916 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Acton Idaho. DATE OF BURIAL: Sept 28 1916

20. UNDERTAKER: J. Gallogly. ADDRESS: Burley Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17
Primary Registration District No. 2196
(No. ....., ... St.)

File No. 15577
Registered No. 131

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Byron Polly.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 18 (Day) 1914 (Year)

7. AGE: 2 Yrs. 3 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Cassia Co. Ida.

10. NAME OF FATHER: Lalie C. Polly.

11. BIRTHPLACE OF FATHER (State or Country): Clark Co. Iowa.

12. MAIDEN NAME OF MOTHER: Ruda Boner.

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. C. Polly
(Address) Burley, Ida R-3

15. Filed Sept 8th 1916. D. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidental drowning
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Gallogly = Coroner = M. D.
Sept. 9 1916. (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Sept. 7 1916

20. UNDERTAKER: J. J. Gallogly. ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 15578
Registered No. 133

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Draper.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (X) Sept (Month) 2 (Day) 1916 (Year)

7. AGE: ..... Yrs. ..... Mos. 11 hrs. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Burley Ida.

10. NAME OF FATHER W.H. Draper.

11. BIRTHPLACE OF FATHER (State or Country) Sanpete Co. Utah.

12. MAIDEN NAME OF MOTHER Lavora Mann

13. BIRTHPLACE OF MOTHER (State or Country) Salt Lake Co. Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W H Draper
(Address) Burley Idaho

15.
Filed Oct. 3rd 1916. Dr. J. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1916, to Sept 2 1916, that I last saw h[illegible] alive on Sept 2 1916, and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Premature Birth

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

9/13 1916 (Signed) C.F. Smith M. D.
(Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Sept 3 1916.

20. UNDERTAKER: [illegible] Cogley ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
(No. ..... St.)

File No. 15579
Registered No. 737

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lea B. Roper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Oct (Month) 16 (Day) 1888 (Year)

7. AGE
28 Yrs. 11 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Polk Co. Missouri

10. NAME OF FATHER
L. L. Brock.

11. BIRTHPLACE OF FATHER
(State or Country) Polk Co Missouri

12. MAIDEN NAME OF MOTHER
Josephine Edwards

13. BIRTHPLACE OF MOTHER
(State or Country) Webster Co. Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W M Roper.
(Address) Burley Ida.

15.
Filed Sept. 17th 1916.
Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Hemorrhage caused by cutting throat
Suicide.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. Allcock. - Coron. M. D.
Sept 17th 1916 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida.
DATE OF BURIAL: Sept 21 1916

20. UNDERTAKER: R. W. Watt
ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

EVANS - YORK CO., PTRS. & BKBS. 24953

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 15580
Registered No. 137

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ruby Belcher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
July (Month) 30 (Day) 19 (Year)

7. AGE
10 Yrs. 1 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... In School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Marion Ida.

10. NAME OF FATHER
Henery Albert Belcher

11. BIRTHPLACE OF FATHER
(State or Country) West Va.

12. MAIDEN NAME OF MOTHER
Alvaretta J. Toolman

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H A Belcher
(Address) Burley Ida.

15.
Filed Sept. 15th 1916. Dr. J. Patterson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept. (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Fracture of skull at base of Brain.
Aeroplane accident
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. B. Falconer — Coroner — M. D.
Sept 16 1916 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Ida — DATE OF BURIAL: Sept 16 1916

20. UNDERTAKER: L. B. Falconer. — ADDRESS: Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 15581
Registered No. 136

1. PLACE OF DEATH.
County of Cassia
City of Burley.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie Price McFee.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Married~~ Widowed

6. DATE OF BIRTH. Oct (Month) 11 (Day) 1865 (Year)

7. AGE: 51 Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... dressmaker.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Clark Co. Mo.

10. NAME OF FATHER George Christopher Stephens

11. BIRTHPLACE OF FATHER (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Elisebeth L. Wade

13. BIRTHPLACE OF MOTHER (State or Country) Medina Co. Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dr. J. Margum
(Address) Rupert Ida.

15. Filed Sept 25th 1916. Dr. J. C. Patterson Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep (Month) 24. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1916, to Sept 24 1916, that I last saw her alive on Sept 24 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Terminator Syphilitic Meningitis

8 (Duration) 8 Yrs. mos. ds.
Contributory (Secondary) Cerebral apoplexy
2 weeks.
(Duration mos. ds.

(Signed) Oscar Fremstad M. D.
19..... (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: Sept 27 1916

20. UNDERTAKER: L. B. Falloon — ADDRESS: Burley Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 15582
Registered No. 138

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maud Maultrie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH.
Jan (Month) 2 (Day) 1853 (Year)

7. AGE
33 Yrs. 8 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Salt Lake City Utah

10. NAME OF FATHER Thomas Robison

11. BIRTHPLACE OF FATHER
(State or Country) Salt Lake City Utah

12. MAIDEN NAME OF MOTHER Mary Smith

13. BIRTHPLACE OF MOTHER
(State or Country) Cole Co. Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas Robison
(Address) Burley Ida R.F.D.

15.
Filed Oct 1st 1916. Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1916, to Sept 1916, that I last saw h... alive on 29th Sept 1916, and that death occured on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:
Gastric Cancer

(Duration) Probably 10 months

Contributory (Secondary) ..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr. J. C. Story M. D.
19..... (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Heise Ida — DATE OF BURIAL: Oct 2nd 1916

20. UNDERTAKER: L. B. Gallogly — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BOOK. 24653

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Ida. 15583
BOARD OF HEALTH
Bureau of Vital Statistics
File No. [redacted]
Registered No.

1. PLACE OF DEATH.
County of Elem
City of Ola

Registration District No.
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If usual residence, give facts called for under special information.

2. FULL NAME Baby Young

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: April (Month) 12 (Day) 1915 (Year)

7. AGE: yrs. 10 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Ola. Ida.

10. NAME OF FATHER Walter Young

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Teresa Bresheres

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Young
(Address) Ola. Ida

15.
Filed 191
E Vadney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9th Feb 1916, to 10 Feb. 1916 that I last saw her alive on 10th 1916, and that death occurred on the date stated above, at 8:15 A. M.

The CAUSE OF DEATH* was as follows:
Obstruction of bowels

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A. Shipp M. D.
Feb 19 1916 (Address) Sweet Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ola
DATE OF BURIAL: Feb. 11th 1916

20. UNDERTAKER —
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DO NOT WRITE IN SPACE RESERVED FOR BINDING

STATE-YORK CO., PRINTERS & BINDERS, BOISE 18172

By Dws.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Fremont

City of Dubois

Registration District No. 125

Primary Registration District No. 2203

(No. .... St.)

File No. 15584

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annie E Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 10 (Day) 1877 (Year)

7. AGE: 39 Yrs. 5 Mos. 10 ds.

IF LESS than 1 day how many: ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Carl a Anderson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Mettie Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Conrad S Allen

(Address) Dubois Idaho

15. Filed 10-24 1916

C E Jones M D
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1916, to Oct 20 1916, that I last saw her alive on Oct 12 1916, and that death occured on the date stated above, at 1:30 P M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) Yrs. 9 mos. 16 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C E Jones M. D.

19.... (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Dubois Idaho

19. PLACE OF BURIAL OR REMOVAL: Dubois — DATE OF BURIAL: Oct 24 1916

20. UNDERTAKER: None — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15585

Registered No. 247

1. PLACE OF DEATH.

County of Ada.

City of Boise.

(No. St. Lukes Hospital. St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earley McPherson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
m.	W.	Married (write the word.)

6. DATE OF BIRTH. March 11 1869
(Month) (Day) (Year)

7. AGE 47 Yrs. 7 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) California.

10. NAME OF FATHER Not Obtainable.

11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E. Mc Pherson

(Address) Hagerman Idaho

15. Filed 10/30 1916 E. J Caton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 30 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1916, to Oct 29 1916, that I last saw h... alive on Oct 29 1916, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs
+ Hyaemia

(Duration) Yrs. 1 mos. 20 ds.

Contributory (Secondary) .....
(Duration ... yrs. ... mos. ... ds.

(Signed) James L. Stewart M. D.

10/30/1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hagerman Idaho.	Oct 31 1916
20. UNDERTAKER	**ADDRESS**
Fry & Summers Co.	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 1707 Warm Springs Ave)

File No. 15586
Registered No. 245

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benjamin F. Elder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. January 1 (Month) (Day) 1843 (Year)
7. AGE: 73 Yrs. 9 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Capitalist
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Illinois
10. NAME OF FATHER: Not obtainable
11. BIRTHPLACE OF FATHER (State or Country): Not obtainable
12. MAIDEN NAME OF MOTHER: Not obtainable
13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. B. Eldridge
(Address) Boise Idaho.
15. Filed 10/28 191 6
E. J. Colvin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 27th (Month) (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1916, to Oct 27 1916, that I last saw h[illegible] alive on Oct 27 1916, and that death occured on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:
Uraemia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Brights disease
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. A. Springer M. D.
Oct 28 1916. (Address) Boise.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 29 1916
20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 1310 North 15th St.)

File No. 15587

Registered No. 244

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothea Caroline Dreilich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 7 (Day) 1898 (Year)

7. AGE: 18 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Otto Dreilich

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Helen Anderson

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. H. Anderson

(Address) 143 E. Bannock St. Boise

15. Filed 10/28 (Month) 6 (Day) 191 (Year)

E. L. Pettit
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1916, to Oct 25 1916, that I last saw h[illegible] alive on Oct 25 1916, and that death occured on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Ulcer Stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. V. Gennway M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: Oct. 29 1916

20. UNDERTAKER: Schreiber & Hidenbaden — ADDRESS: Boise

Dr. [illegible] Gennway

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15588
Registered No. 243

1. PLACE OF DEATH.
County Ada
City of Boise (No. 410 S. 4th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leonara May Roberts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept 18 1873 (Month) (Day) (Year)

7. AGE: 43 Yrs. 1 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Vivian Cooper

11. BIRTHPLACE OF FATHER (State or Country): Ark.

12. MAIDEN NAME OF MOTHER: Julia A. Hawkins

13. BIRTHPLACE OF MOTHER (State or Country): Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wesley W Roberts
(Address) Boise

15. Filed 10/28 191 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1916, to Oct 26 1916, that I last saw h[illegible] alive on Oct 26 1916, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James L Stewart M. D.
19 .... (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 29 1916

20. UNDERTAKER: Schreiber & Hodgins — ADDRESS: Boise

Stewart

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15589

Registered No. 242

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 2309 N. 16. St.)

Registration District No.

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Sullivan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Oct (Day) 26 (Year) 1916

7. AGE: ....Yrs....Mos. 2 ds.

IF LESS than 1 day how many....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Oscar E. Sullivan

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Lilly M. Pierce

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Oscar E. Sullivan
(Address) 2309 - N. - 16th St.

15.
Filed 10/22 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1916, to Oct 23 1916, that I last saw him alive on Oct 22 1916, and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Atelektasis

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Prematurity

(Duration yrs. mos. 2 ds.

(Signed) Thomas N. Bratton M. D.

Oct 23 1916 (Address) 509 Empire Bldg Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 23 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRN - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15590

Registered No. 240

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 412 State St. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jesse D. Rigdon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 23 (Day) 1897 (Year)

7. AGE: 19 Yrs. 0 Mos. 27 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Messenger
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Albert Rigdon

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Myrtle Bailey

13. BIRTHPLACE OF MOTHER (State or Country): Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alva Bailey
(Address) Soldiers Home

15. Filed 10/21 191 6

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 20 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 191 6, to Oct 20 191 6, that I last saw h— alive on 20 Oct 191 6, and that death occured on the date stated above, at 6P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J P E Swartz M. D.

Oct 21 19 16 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 22 191 6

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Idaho

BYRNE - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15591

Registered No. 259

1. PLACE OF DEATH.

County of Ada.

City of Boise

Registration District No 2

Primary Registration District No 1004

(No. 1st & Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orlando S. Goff.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sep 10 (Month) (Day) 1843 (Year)

7. AGE 73 Yrs. 1 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Photographer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Conn

10. NAME OF FATHER Alfred Goff.

11. BIRTHPLACE OF FATHER (State or Country) Conn

12. MAIDEN NAME OF MOTHER Adelade Case

13. BIRTHPLACE OF MOTHER (State or Country) Conn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Annie E. Goff.
(Address) .....

15. Filed 10/17 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Mohth) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 13th 1916, to Oct 17 1916, that I last saw h. in alive on Oct. 16 1916, and that death occured on the date stated above, at 7.20 A. M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

4 (Duration) — Yrs. — mos. 4 ds.

Contributory (Secondary) Portal Carcinoma

(Duration) 7d yrs. — mos. — ds.

(Signed) H. Coonfield M. D.

Oct 19 16 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Oct 18 1916

20. UNDERTAKER: Fry & Summers Co — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMS - YORK CO., PTRS. & BDRS. 24653

1. PLACE OF DEATH.
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. 307 N. 19 St.)

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15592
Registered No. 238

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Jan (Month) 30, (Day) 18[illegible] (Year)

7. AGE: 53 Yrs. 8 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Frederick Hartz

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E D Taylor
(Address) Boise Idaho

15. Filed 10/16 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 13" (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20. 1916; to Oct 13 1916, that I last saw her alive on Oct 13 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

10/16 1916 (Address)

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/16 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BOOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15593

Registered No. 235

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 1320 N. 5 St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doris E. Eddy.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.):

6. DATE OF BIRTH. Aug (Month) 21st (Day) 1914 (Year)

7. AGE: 2 Yrs. 1 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Havre, Mont

10. NAME OF FATHER Louis Eddy

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Jessie Hamm

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. C. Sloan

(Address) Boise, Idaho

15.

Filed 10-9 1916

E. A. Clinton Local Registrar

Collister

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible] 1916, to [illegible] 1916, that I last saw h[illegible] alive on ..... 191..., and that death occured on the date stated above, at 11-30 P.M.

The CAUSE OF DEATH* was as follows:

Cholera-morbus

(Duration) 2 Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Livingston, Mont

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 10/10 1916

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15594

Registered No. 234

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No.

(No. 620, S. 16th 1004 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jos. K. Paxton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 8th (Day) 1846 (Year)

7. AGE: 70 Yrs. 2 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Guernsey Co. Ohio

10. NAME OF FATHER: James Paxton

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. Paxton

(Address) Boise

15. Filed 10-9 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 8th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1916, to Oct 7 1916, that I last saw h[illegible] alive on Oct 7 1916 and that death occured on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows: Cancer - left side face

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. V. Hennessy M. D.

19..... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State...yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Ada County, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/10 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYUS - YORK CO., PTRS. & BORS. 24653

Approved

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 15595

Registered No. 737

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 620 S. 16 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary A. Paxton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. July (Month) 22 (Day) 1844 (Year)

7. AGE: 72 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Pittsburg, Penn

10. NAME OF FATHER Andrew Trissman

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. Paxton

(Address) .....

15. Filed 10-14 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/12 1916 to 10/12 1916, that I last saw her alive on 10/12 1916, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Chr. Bronchitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ralph Todd M. D.

10/13 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Ada County, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/14 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Frank

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 State St.)

Registration District No. 2

Primary Registration District No. 1004

File No. 15596

Registered No. 236

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Diza Wells.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Jan (Month) 18th (Day) 1851 (Year)

7. AGE: 65 Yrs. 8 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dubuin Idho

10. NAME OF FATHER: Louis Wells.

11. BIRTHPLACE OF FATHER (State or Country): Ohio Idho

12. MAIDEN NAME OF MOTHER: Nancy Weeks

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Clara Jarvis

(Address)

15. Filed 10-16 1916

W. F. Lutz
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 10th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1916, to Oct 10 1916, that I last saw h[illegible] alive on Oct 9 1916, and that death occured on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Chronic interstetial kephritis

(Duration) Several Yrs. mos. ds.

Contributory (Secondary) Old age

(Duration yrs. mos. ds.

(Signed) W. J. Lewis M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence Mountain City, Nev.

19. PLACE OF BURIAL OR REMOVAL: Mt City, Nev.

DATE OF BURIAL: 10/16 1916

20. UNDERTAKER: Schreiber & Sidenfaden

ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNES - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

(No. St Alphonsus Hosp. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15597

Registered No. 223

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurred away from usual residence, give facts called for under special information.

2. FULL NAME Edith E. Stoddard.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	White	Married

6. DATE OF BIRTH. Apr 29 1 (Month) (Day) (Year)

7. AGE 52 Yrs. 5 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9. BIRTHPLACE (State or Country) New York.

10. NAME OF FATHER Armstrong.

11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur E Stoddard

(Address) Nampa Idaho

15. Filed 10-9 1916

E. H. Potts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 7 16 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1916, to Oct 7 1916, that I last saw h[illegible] alive on Oct 6 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Uraemia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

Duration ..... yrs. 6 mos. ..... ds.

(Signed) [illegible] M. D.

19.... (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Oct 8 1916

20. UNDERTAKER: Fry & Summers. — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 15598

Registered No. 232

1. PLACE OF DEATH.

County of Ada.

City of Boise.

(No. St. Lukes Hospital. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Loene Easter.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 6 (Day) 1915 (Year)

7. AGE: 1 Yrs. 2 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Raymond S. Easter.

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Mary E. Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond S. Easter

(Address)

15. Filed 10-3 1916

E S Eaton
Local Registrar

8

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 3 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2nd 1916, to Oct 3 1916, that I last saw her alive on Oct 3 1916, and that death occured on the date stated above, at 3 30 M.

The CAUSE OF DEATH* was as follows:

Heart failure
caused by
malnutrition

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Otis Borck M. D.

10-3 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Oct 3 1916

20. UNDERTAKER: Frye & Summers Co. ADDRESS: Boise Ida.

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
(No. ..... St.)

File No. 15599
Registered No. 58

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada
City of Near Boise

2. FULL NAME Winn Archer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6. DATE OF BIRTH. June 29 (Month) (Day) 1916 (Year)

7. AGE Yrs. 3 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF FATHER J E Archer

11. BIRTHPLACE OF FATHER (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Elyabeth Frank.

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J E Archer

(Address) Boise R R No 2

15. Filed Oct 9 1916 E. F. Coates Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1916, to Oct 9 1916, that I last saw h[illegible] alive on July 15 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Congenital Malformation

(Duration) ..... Yrs. 3 mos. 9 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W S Lee M. D.

Oct 9 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Morris Hill — **DATE OF BURIAL** Oct 9 1916

20. UNDERTAKER Frye & Summers — **ADDRESS** Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 15600
Registered No. 60

1. PLACE OF DEATH.
County of Boise
City of Quartzburg
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothey Margerete Kibble

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Maude (Month) 19 (Day) 1915 (Year)

7. AGE
1 Yrs. 9 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Ida

10. NAME OF FATHER: M. C. Kibble

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Agnes M. Keane

13. BIRTHPLACE OF MOTHER (State or Country): Boise

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. C. Kibble
(Address) Quartzburg Idaho

15.
Filed Oct 25 1916 E. F. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1916, to Sept 6 1916, that I last saw h[illegible] alive on Sept 6 1916, and that death occured on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:
Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W S Dillon M. D.

10-25 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct. 26 1916

20. UNDERTAKER: Schreiber & Hedenstrom — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

File No. 15601

County of Ada

City of

(No. 1 Mile So of Cloverdale School)

Registered No. 61

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Heffner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 15th (Day) 1833 (Year)

7. AGE: 83 Yrs. — Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hanover, Prussia

10. NAME OF FATHER: not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Heffner

(Address)

15. Filed Oct 28 1916 E. F. Heaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 26th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13, 1916, to Oct 26 1916, that I last saw h[illegible] alive on Oct 26 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) Yrs. — mos. ds.

Contributory (Secondary) Obstruction Jaundice

(Duration yrs. 1 mos. ds.

(Signed) E. E. Frazer M. D.

1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Oct 29 1916

20. UNDERTAKER: Schreibut & Eidenfoder | ADDRESS: Boise

Female

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2007
File No. 15602
Registered No. 62

1. PLACE OF DEATH.
County of Boise
City of
(No. Bear Valley St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Fahey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 17 1840 (Month) (Day) (Year)

7. AGE: 76 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: John Fahey

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. H. Ballangrud
(Address) Boise

15. Filed Oct 28 1916
E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ on 25th October 1916 to ~~1916~~ 191..., that I last saw him alive on 25th October 1916 and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Mr Boston in attendance died suddenly in the Morris Hill

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Ballangrud Friend
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Oct 28 1916

20. UNDERTAKER: Schreiber & Sedgwick | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMB - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 15603
Registered No. 63

1. PLACE OF DEATH.
County of Ada
City of 11 miles S.W. of Boise (If not in incorporated limits, so state.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsie West.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Apr (Month) 11 (Day) 1908 (Year)

7. AGE: 8 Yrs. 6 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): So. Dakota

10. NAME OF FATHER: Charles West.

11. BIRTHPLACE OF FATHER (State or Country): Finland.

12. MAIDEN NAME OF MOTHER: Louisa Jons

13. BIRTHPLACE OF MOTHER (State or Country): Finland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas. West
(Address) Boise Ida

15. Filed Oct 31 1916 E. F. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1916, to Oct 28 1916, that I last saw h alive on Oct 28 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R E Sturgis M. D.

Oct 29 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Oct 31 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAMP - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2014

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15604

Registered No. 59

1. PLACE OF DEATH.

County of Ada

City of Near Boise (No. Near Boise St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice J. Fender

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 11 (Day) 1853 (Year)

7. AGE: 62 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Emanuel Wagner

11. BIRTHPLACE OF FATHER (State or Country): Maryland

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Maryland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. R. Fender

(Address) Boise R.D. No 1

15.

Filed Oct 23 1916

E. F. Keator
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ visited deceased from Sept 1 1916, to Oct 22 1916, that I last saw h.. alive on Oct 22 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

(Duration) 1 Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) E. Fromm M. D.

19 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 24 1916

20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 8004

File No. 15605

Registered No. 57

1. PLACE OF DEATH.

County of Ada

City of ——

(No. Briggs Crossing St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William M. Briggs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Sept 24 1847 (Month) (Day) (Year)

7. AGE: 69 Yrs. —— Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired Rancher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Hiram O. Briggs

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Perlina Woods

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. W. Briggs.
(Address) Boise.

15. Filed Oct 7 1916 E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 5th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1916, to Oct 5 1916, that I last saw h alive on about Sept 28 1916, and that death occured on the date stated above, at 5 p M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Springer M. D.

Oct 7 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct. 7 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & RDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 1007

(No. 343 East Judicial St.)

File No. 15606

Registered No. 85

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hannah Shaw

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 26 (Day) 1916 (Year)

7. AGE: ....Yrs. ....Mos. ....ds. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Blackfoot, Idaho

10. NAME OF FATHER Peter Shaw

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Alice Pendlebury

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Peter Shaw
(Address) Blackfoot

15.
Filed Oct 24 1916
M. E. Tuttle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1916, to Oct 23 1916, that I last saw her alive on Oct 23 1916, and that death occured on the date stated above, at 11P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia 7 ms

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

....(Duration ....yrs. ....mos. ....ds.

(Signed) J. O'Neil Hall M. D.

10/23 1916 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence....

19. PLACE OF BURIAL OR REMOVAL: Grove City cemetery — DATE OF BURIAL: Oct 24 1916

20. UNDERTAKER: E J Funk — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 721
Primary Registration District No. 1007
File No. 15608
Registered No. 92

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. 299 So. Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Lindsay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. Jan (Month) 18 (Day) 1900 (Year)

7. AGE 16 Yrs. 8 Mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER John Lilly

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Martha Cooper

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. E. Lindsay
(Address) Inkom, Idaho

15. Filed Oct 5 1916 W. E. Parke Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1916, to Oct 5 1916, that I last saw her alive on Oct 5 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(Duration) — Yrs. — mos. 16 hrs ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Beck M. D.

10/5 1916 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iona City cemetery — DATE OF BURIAL: Oct 7 1916

20. UNDERTAKER: E. J. Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 15609
Registered No. 83

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot Ida (No. ..... St.)
outside city limits
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Beel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Oct (Month) 25 (Day) 1841 (Year)

7. AGE: Yrs. 74 Mos. 11 ds. 16
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Derick Beel

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Elizabeth Turner

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm D. J. Knox
(Address) Blackfoot Ida

15. Filed Oct 12 1916 M. E. Petrie Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1916, to Oct 11 1916, that I last saw h[illegible] alive on Oct 11 1916, and that death occured on the date stated above, at 9:50 A.M.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(Duration) 5 Yrs. — mos. — ds.

Contributory (Secondary): Uremia

(Duration — yrs. — mos. 5 ds.

(Signed) J B Davis M. D.

(Address) Blackfoot Ida

Oct 12 1916

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Blackfoot — DATE OF BURIAL: Oct 13 1916

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 15610
Registered No. 84

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dalton Broadhead

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 30 (Day) 1915 (Year)

7. AGE: ..... Yrs. 11 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: David L. Broadhead

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David L. Broadhead
(Address) Blackfoot, R. 2

15.
Filed Oct 22 191 6
M. E. Patrie
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1916, to Oct 22 1916, that I last saw him alive on Oct 22 1916, and that death occured on the date stated above, at 9:00 A.M.

The CAUSE OF DEATH* was as follows:
Menengitis
(Duration) about 3 days
Contributory (Secondary) Otitis media
(Duration 7 days)
(Signed) W. W. Beck M. D.
10/22 1916 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Thomas Riverside — DATE OF BURIAL: 191

20. UNDERTAKER: E. F. Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ..... St.)

File No. 15611
Registered No. [illegible]

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rhoda Mable Van Orden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 31 (Day) 1884 (Year)

7. AGE: 31 Yrs. 11 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Jacob Orlando Jones

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Nellie Sanburg

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. J. Van Orden
(Address) Blackfoot Idaho

15. Filed Oct 30 1916 M. E. Parkie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1916, to Oct 29 1916, that I last saw her alive on Oct 29 1916, and that death occured on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Subphrenic abscess

(Duration) — Yrs. — mos. 4 ds.

Contributory (Secondary) Puerperal sepsis

(Duration — yrs. — mos. 9 ds.

(Signed) W. W. Beck M. D.

10/30 1916 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thomas-Fairview | DATE OF BURIAL: Oct 31 1916

20. UNDERTAKER: J. L. Van Orden | ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOOS. 24655

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15612

Registered No. 87

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2194

(No. Idaho Insane Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME C. M. Holmes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7. AGE 86 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ills.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. M. Poynter

(Address) Blackfoot Rur Rt

15. Filed Oct 30 1916 M. E. Dustin Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 6 1915, to Oct 25 1916, that I last saw him alive on Oct 24 1916, and that death occured on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Pleurisy

(Duration) Unknown Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. M. Poynter M. D.

10-28 1916 (Address) Blackfoot Rur Rt

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 8 mos. ..... days In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Blackfoot Rur Rt

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
In asylum cemetery	10/28 1916

20. UNDERTAKER	ADDRESS
A. D. Forrest	Asylum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15613

Registered No. 88

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot Ida. (No. Idaho Insane Asylum St.)

Registration District No. 121

Primary Registration District No. 2140

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herbert J. Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Apr (Month) 20 (Day) 1878 (Year)

7. AGE: 38 Yrs. 6 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. D. Ferrell

(Address) Blackfoot Ida

15. Filed Aug 27 1916 M. E. Pahia Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1916, to Oct 25 1916, that I last saw him alive on Oct 25 1916, and that death occured on the date stated above, at 7.30 P M.

The CAUSE OF DEATH* was as follows:

General Paresis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. N. Jones M. D.

10.26.1916 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 6 mos. 15 days In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: E Burial Idaho — DATE OF BURIAL ..... 191...

20. UNDERTAKER: E J [redacted]k — ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRD - RICHARDSON PTG. CO., PTGS. & ENGR. 24055

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 15615
Registered No. 38

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Nelson Graham
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
May (Month) 25 (Day) 1865 (Year)

7. AGE
51 Yrs. 4 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Samuel Graham

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. L. Graham
(Address) Grangeville Ida

15.
Filed Nov 3 1916 S S Stockton Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October (Month) 18th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ investigated the death of deceased
..... 191..., to ..... 191...,
~~that I last saw him alive~~ on Oct 18th 1916,
and that death occured on the date stated above, at about 4 A.M.

The CAUSE OF DEATH* was as follows:
Natural Causes Unknown

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) W B Blakie M. D.
10/18 1916 (Address) Coroner of Idaho County Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View
DATE OF BURIAL: Oct 20 1916

20. UNDERTAKER: A. J. Maugg
ADDRESS: Grangeville

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 193
Primary Registration District No. 1001
File No. 15616
Registered No. 37

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jobe Scott Mason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Oct (Month) 21 (Day) 1884 (Year)

7. AGE: 32 yrs. ..... mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Edmond Mason

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Elesebeth Hayworth

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lizzie Harris.
(Address) Grangeville Ida

15. Filed Nov 3 1916 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1916, to Oct 25 1916, that I last saw him alive on Oct 1 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Arteria-Sclerosis

(Duration) unknown yrs. ..... mos. ..... ds.

Contributory (Secondary) Bright's disease

(Duration) unknown yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.

10/27 1916 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Prairie View	10/27 1916

20. UNDERTAKER	ADDRESS
E. B. Hancock	Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Denver
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181
(No. ....., ... St.)

File No. 15617
Registered No. 36
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fannie Alice Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Sept (Month) 9 (Day) 1902 (Year)

7. AGE: 14 yrs. 1 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Harrison Johnson

11. BIRTHPLACE OF FATHER (State or Country): Illonois

12. MAIDEN NAME OF MOTHER: Marie or Kennels

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary M Johnson
(Address) Denver Idaho

15. Filed Nov 3 1916 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1916, to Oct 26 1916 that I last saw her alive on Oct 26 1916 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) ..... yrs. 1 mos. 7 ds.
Contributory (Secondary) Post operative paralysis
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) G S Stockton M. D.
10/27 1916 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Denver Idaho
DATE OF BURIAL: 10/27 1916

20. UNDERTAKER: E S Hancock
ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 15618
Registered No. 35

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Cole

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH
June (Month) 6 (Day) 1856 (Year)

7. AGE
60 yrs. 3 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farming Stock
(b) General nature of industry business, or dstablishment in which employed (or employer) ..... Farming

9. BIRTHPLACE
(State or Country) Austen, Texas

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country) Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe Mires
(Address) Grangeville Ida

15.
Filed Nov 2 1916 G S Sticklen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
October (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1916., to Oct 4 1916., that I last saw him alive on Oct 4 1916, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Uraemia and Myocardial degeneration

(Duration) — yrs. — mos. 3 ds.
Contributory Arteria Sclerosis &
(Secondary) Brights Disease
(Duration) 10 yrs. — mos. — ds.

(Signed) C. A. Slusser M. D.
Oct 5 1916. (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Prairie View
DATE OF BURIAL: Oct 5 1916

20. UNDERTAKER: E D Hancock
ADDRESS: Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 15619
Registered No. 34

1. PLACE OF DEATH.
County of Idaho
City of Grangiville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Seth Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 6 (Day) 1833 (Year)

7. AGE: 83 yrs. 5 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer): Stock Man

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: ? Jones

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Miss Lamphere

13. BIRTHPLACE OF MOTHER (State or Country): not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) L. M. Jones Grangeville Ida

15. Filed Nov 2 1916 G B Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29 1916, to Oct 1 1916, that I last saw h[im] alive on Oct 1 1916, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Senile Debility
.....
.....
..... (Duration) ..... yrs. 3 mos. — ds.
Contributory (Secondary) Cerebral Hemorrhage
..... (Duration) 6 yrs. — mos. — ds.
(Signed) C. N. Gleason M. D.
Oct 4 1916 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Grangeville | DATE OF BURIAL: Oct 4 1916

20. UNDERTAKER: P. J. Maugg | ADDRESS: Cottonwood

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Nezperce
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181
(No. ....., ... St.)

File No. 15620
Registered No. 33
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orin Joseph Stockdale

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH
Nov (Month) 9 (Day) 1877 (Year)

7. AGE
39 yrs. 11 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Minnesota

10. NAME OF FATHER Charles Stockdale

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Hellen Stockdale

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizzid Stockdale
(Address) Roseburg Oregon

15.
Filed Nov 2 1916 G S Blockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
October (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on Sept. 17 1916,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Acute indigestion

(Duration) ..... yrs. 1 mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jesse L. Rains M. D.
Dec 31 1916 (Address) Grangeville, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....dsys.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Roseburg Oregon
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: G S Hancock
ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon Co
City of Parma
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8
Primary Registration District No. 507
(No. ..... , ... St.)

File No. 15621
Registered No. 19
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jack Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M	W	W (Single, Married, Widowed, Divorced)

6. DATE OF BIRTH: Do not Know (Month) (Day) 1 (Year)

7. AGE: About 66 years (yrs.) (mos.) (ds.)
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Do not Know

10. NAME OF FATHER: Do not Know

11. BIRTHPLACE OF FATHER (State or Country): Do not Know

12. MAIDEN NAME OF MOTHER: Do " "

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ha Carlyle
(Address) Parma

15.
Filed Oct 18 1916 Lulu Waldrop
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Found Dead
Cause Heart failure
1 (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A. A. Faris Coroner Canyon Co
19.... (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL [redacted] Parma Ida — DATE OF BURIAL Oct 18 1916

20. UNDERTAKER Peckham Coe & — ADDRESS Parma

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 8
County of Canyon Primary Registration District No. 2007
City of Parma District (No. ——, —— St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 15622
Registered No. 20
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME —— Sabin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	Single

6. DATE OF BIRTH: Oct (Month) 9 (Day) 1916 (Year)

7. AGE: — yrs. — mos. — ds. IF LESS than 1 day how many 3 hrs. or ..... min.

8. OCCUPATION
(a) Trade, professsion, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Harry Sabin

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Blanche Welbourne

13. BIRTHPLACE OF MOTHER (State or Country) N. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. H. Sabin
(Address) Parma, Ida.

15.
Filed Oct 1916 Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1916, to Oct 9 1916
that I last saw h im alive on Oct 9 1916,
and that death occurred on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:
Prematurity — (5½ mos.)

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. B. Allen M. D.
10-9 1916 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: near home
DATE OF BURIAL: Oct. 9 1916

20. UNDERTAKER —
ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15623

Registered No. 2

1. PLACE OF DEATH.

County of Canyon

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Bennie Hatch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
F	W	M (Write the word.)

6. DATE OF BIRTH: Oct (Month) 25 (Day) 1840 (Year)

7. AGE: 76 yrs. mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Novascotia

10. NAME OF FATHER: Do not Know

11. BIRTHPLACE OF FATHER (State or Country): Do not Know

12. MAIDEN NAME OF MOTHER: Do not Know

13. BIRTHPLACE OF MOTHER (State or Country): Do not Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Wenn
(Address) Parma Idaho

15.
Filed Oct 29 1916 Hubert Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 23 1916, to Oct. 27 1916, that I last saw her alive on Oct. 25 1916, and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
General debility due to Cardiac insufficiency & contributed to by old age.

(Duration) 0 yrs. 3 mos. — ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) D. S. Chambers M. D.
19 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..yrs..mos..days. In the State ..yrs..mos..days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Roswell Cemetary — DATE OF BURIAL: Oct 29 1916

20. UNDERTAKER: Peckham Case Co — ADDRESS: Parma Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15624

Registered No. 218

1. PLACE OF DEATH.

County of Canyon

City of Parma

(No. ....., ... St.)

Registration District No. 8

Primary Registration District No. 2087

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Not Named

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 5 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds. —

IF LESS than 1 day how many 8½ hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Andy Nelson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Mary Kirkland

13. BIRTHPLACE OF MOTHER (State or Country) N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Kirkland Nelson

(Address) Parma, Idaho

15. Filed Oct. 6 1916. Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 5 1916, to Oct. 6 1916, that I last saw him alive on Oct 5 1916, and that death occured on the date stated above, at 5-9 M.

The CAUSE OF DEATH* was as follows:

absence of parital bones, partial absence of occipital, temporal & frontal bones.

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) Convulsions

(Duration — yrs. — mos. — ds.

(Signed) W. J. Waldrop M. D.

Oct 6 1916 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parma

DATE OF BURIAL: Oct 6 1916

20. UNDERTAKER: Parma

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5
Primary Registration District No. 6009

File No. 15626
Registered No. 4

1. PLACE OF DEATH.
County of Canyon
City of New Plymouth (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis G. McCarthy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Jan (Month) 22 (Day) 1857 (Year)

7. AGE
59 Yrs. 7 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Lafyette

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Blanda Peak

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Adgie McCarthy
(Address) New Plymouth

15.
Filed ..... 191....
Wm J Drysdale
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
September (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from one or two 1916, to years previous death
that I last saw h im alive on Sept. 16 1916,
and that death occured on the date stated above, at 9 9 M.

The CAUSE OF DEATH* was as follows:
Loco Motor ataxia
several
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
Sero
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Wm T Drysdale M. D.
9-17 1916 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Plymouth Idg
DATE OF BURIAL: 9-17 1916

20. UNDERTAKER: A. Meyer.
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 5

Primary Registration District No. 2009

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15627

Registered No. 3

1. PLACE OF DEATH.

County of Canyon

City of New Plymouth

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ringar

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: f

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Enfant

6. DATE OF BIRTH. Aug (Month) 30 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho -

10. NAME OF FATHER Fred Ringar

11. BIRTHPLACE OF FATHER (State or Country) Nova Scotia

12. MAIDEN NAME OF MOTHER Meta Day.

13. BIRTHPLACE OF MOTHER (State or Country) England -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N. F. Ringar

(Address) New Plymouth.

15. Filed 9-2 1916 Wm I. Dryedale Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30 1916, to Sept 1 1916, that I last saw her alive on Aug 31 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Insufficient foetal development

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm I Dryedale M. D.

9-1 1916 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: New Plymouth — DATE OF BURIAL: Sept 2 1916

20. UNDERTAKER: N. F. Ringar — ADDRESS: New Ply.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15629

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of " "

Registration District No. 40

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur Wiseman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unknown (Month) 1 (Day) (Year)

7. AGE: About X — 40 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Stock Raiser.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: J. F. Wiseman

11. BIRTHPLACE OF FATHER (State or Country): Kentucky.

12. MAIDEN NAME OF MOTHER: Nancy Estes

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. F. Wiseman

(Address) Burke Ida

15. Filed June 26 1916 W. A. Parrett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 25 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Killed by being kick by horse

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas J Crosby M D

19.... (Address) Coroner Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Walla Walla Wash — DATE OF BURIAL ..... 191...

20. UNDERTAKER: C J Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15630

1. PLACE OF DEATH. Registration District No. 40
County of Twin Falls. Primary Registration District No.
City of Hollister (No. , St.) Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howard Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept. 16 (Month) (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: X
(b) General nature of industry business, or establishment in which employed (or employer): X

9. BIRTHPLACE (State or Country): Hollister, Ida.

10. NAME OF FATHER: A. R. Johnson

11. BIRTHPLACE OF FATHER (State or Country): Colorado.

12. MAIDEN NAME OF MOTHER: Lessie Scott,

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. R. Johnson
(Address) Hollister, Ida.

15. Filed Sept. 16 1916 W. A. Parrett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from X 191 X to X 191
that I last saw h.. alive on Aug. 28 1916,
and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Ruptured Appendix
Acute
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. A. Parrett M. D.
Sept. 29 1916 (Address) Hollister Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Rock Creek | DATE OF BURIAL: Sept. 18 1916

20. UNDERTAKER: A. R. Johnson | ADDRESS: Hollister Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15631

Registered No. .....

1. PLACE OF DEATH.
County of Boise
City of Cascade
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15
Primary Registration District No. .....

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Not Known ..... 1 ..... (Month) (Day) (Year)

7. AGE: 66 about yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G E Boggs
(Address) Cascade Ida

15.
Filed Nov. 5 1916 R. McDonald
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 10 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ did not deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemmorrhage
.....
.....
(Duration) 1 hr yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G E Boggs M. D.
11-1 1916 (Address) Cascade Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Vanwyck Ida
DATE OF BURIAL: 10-13 1916

20. UNDERTAKER .....
ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15632

Registered No. 22

1. PLACE OF DEATH. Registration District No.

County of Primary Registration District No. 15

City of (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosa Ward

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fm

4. COLOR OR RACE: wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mch (Month) (Day) 1875 (Year)

7. AGE: 1 yrs. 6 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Waymond Ward

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Lilly Mathews

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G E Noggle
(Address) Cascade Ida

15.
Filed Nov. 5 1916 R. McDonald
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ did not deceased from 191 , to 191
that I last saw h alive on 191 ,
and that death occurred on the date stated above, at 1130 P M.

The CAUSE OF DEATH* was as follows:
Acute Dysentery

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) G E Noggle M. D.
11-1 1916 (Address) Cascade Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Roseberry Ida
DATE OF BURIAL: 10-15 1916

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15633

Registered No. 25

1. PLACE OF DEATH.
County of Boise
City of Cascade
(No. ..... St.)

Registration District No. .....
Primary Registration District No. 15

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo F. Losh

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1861 (Year)

7. AGE: 55 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G E Troggle
(Address) Cascade Ida

15.
Filed Nov 5 1916 C. M. Wood
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jet 21 1916, to 10-12 1916
that I last saw h[illegible] alive on 10-12 1916,
and that death occurred on the date stated above, at 10 hrs. PM.

The CAUSE OF DEATH* was as follows:
Paralysis

(Duration) 8 yrs. 8 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. E. Troggle M. D.
19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Vanwyck Ida
DATE OF BURIAL: 10-15 1916

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee
City of Near King Hill

Registration District No. 43
Primary Registration District No. 2120
(No. ....., ... St.)

File No. 15634
Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed (died 10 hours after birth.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 31st (Day) 1916 (Year)

7. AGE: ~ yrs. ~ mos. — ds.
IF LESS than 1 day how many 10 hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Frederick William Ginney.

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Emma Shultz.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Davis
(Address) Glenn's Ferry Idaho

15.
Filed Aug. 9. 1916 H. H. Schuyler M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31st 1916, to July 31st 1916, that I last saw him alive on July 31st 1916, and that death occurred on the date stated above, at 3:30 P M.

The CAUSE OF DEATH* was as follows:
Asphyxia Neonatorum
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Imperfect development
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Davis M. D.
July 31st 1916 (Address) Glenn's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Near King Hill Idaho	Aug. 1st 1916
20. UNDERTAKER	**ADDRESS**
Frederick William Ginney	King Hill

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15635

Registered No. 34

1. PLACE OF DEATH.

Registration District No. 43

Primary Registration District No. 2120

County of Owyhee

City of Silver City (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Blanty Gregorio

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: about the year 1855 or 1856
(Month) (Day) (Year)

7. AGE: About 60 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner & stock-raiser.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Italy. (or France)

10. NAME OF FATHER: Unknown. (Georges?)

11. BIRTHPLACE OF FATHER (State or Country): Italy. (or France.)

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Italy. (or France.)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Lucchinetta.
(Address) Silver City or Simker Creek.

15.
Filed Sept. 13, 1916 W. H. Delaughter, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (?), 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~inquest of~~ on September 12, 1916, to ..... 191..
that I last ~~saw~~ he was alive on August 7, 1916
and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows: Verdict of Coroner's Jury at inquest, Sept 12'16:- "Died from natural causes probably heart disease, with which he was afflicted, about one month previous to finding body in woods, Sept 11. 1916."

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Delaughter, Co. Coroner, Owyhee M. D.

Sept. 12, 1916 (Address) Silver City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Silver City, Idaho

DATE OF BURIAL: Sept. 12, 1916

20. UNDERTAKER: John Grete

ADDRESS: Silver City, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15636
Registered No. .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.
County of Adams
City of Council
Registration District No. .....
Primary Registration District No. .....
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lasem Edgar Hayter
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: (X) May (Month) 30 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Council Idaho

10. NAME OF FATHER: Lewis G. Hayter

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Nellie Beulah Hogg

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lewis Hayter Sr.
(Address) Council Ida

15. Filed 10/24/16 191.... R. H. McNeeman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30 1916, to June 7 1916, that I last saw him alive on June 7 1916, and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows: Congenital Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. H. McNeeman M. D.
19.... (Address) Council Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Council Ida — DATE OF BURIAL: June 7 1916

20. UNDERTAKER — ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15637
Registered No. 31

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Parker Barrows Wickham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Oct (Month) 15 (Day) 1857 (Year)
7. AGE: 64 Yrs. 11 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Big Run - Athens Co Ohio
10. NAME OF FATHER: Wm Warren Wickham
11. BIRTHPLACE OF FATHER (State or Country): Do not know
12. MAIDEN NAME OF MOTHER: Harriet Ann James
13. BIRTHPLACE OF MOTHER (State or Country): Do not know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Glenn Ellis M.D.
(Address) Mrs C B Wickham
15. Filed Oct. 3 1916 Ed Herndon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 3rd 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1916, to Oct 3 1916, that I last saw h[illegible] alive on Oct 3 1916, and that death occured on the date stated above, at 6-30 A.M.
The CAUSE OF DEATH* was as follows:
Uremic Poisoning
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Bright's disease
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F L Wright M. D.
Oct 4 1916. (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Glen Ullin N Dak — DATE OF BURIAL ..... 191..
20. UNDERTAKER: W. C. Doebler — ADDRESS Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 15638
Registered No. 30

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hyram Stills

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. April (Month) 10 (Day) 1842 (Year)
7. AGE: 74 Yrs. 5 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Stuart Iowa.
10. NAME OF FATHER: Do not know
11. BIRTHPLACE OF FATHER (State or Country): Do Not Know
12. MAIDEN NAME OF MOTHER: Do not know
13. BIRTHPLACE OF MOTHER (State or Country): " " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dave Stills
(Address) Salmon Idaho.
15. Filed Sept. 18, 1916 E. D Henderson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 18th (Month) (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 10 1916, to Aug 1 1916, that I last saw him alive on Aug 1 1916, and that death occured on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Bright's Disease
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. S Wright M. D.
9/18 1916 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~ Salmon Cemetery — DATE OF BURIAL 9-19" 1916
20. UNDERTAKER H C Doelker — ADDRESS Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 46
Primary Registration District No. 2123
(No. ....., ... St.)

File No. 15639
Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Benewah.
City of Plummer.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nina, Pearl, McKee.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
June (Month) 20th (Day) 1890 (Year)

7. AGE
26 Yrs. 3 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Loon Lake, Wash.

10. NAME OF FATHER
Monroe L. Sharp.

11. BIRTHPLACE OF FATHER
(State or Country) Ontario. Canada.

12. MAIDEN NAME OF MOTHER
Amelia Jane Saunders

13. BIRTHPLACE OF MOTHER
(State or Country) St Clare Co. Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Monroe L Sharp
(Address) Cheney Wash

15.
Filed Oct. 18 1916
H. G. Jaeger
Local Registrar

BYNS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13th 1916, to Oct 15 1916, that I last saw her alive on Oct 15 1916, and that death occured on the date stated above, at 6-50 A.M.

The CAUSE OF DEATH* was as follows:
Abortion or miscarriage With Functional and Defective Heart Action.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) S. A. Herrington M.D.
Oct 16 1916 (Address) Plummer Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Plummer, Idaho. DATE OF BURIAL: Oct 17 1916

20. UNDERTAKER: H. G. Jaeger. ADDRESS: Plummer, Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 51
Primary Registration District No. 2130
File No. 3 15640
Registered No. 5

1. PLACE OF DEATH.
County of Canyon
City of Fruitland (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mabel M Sparks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Jan 12 1914 (Month) (Day) (Year)

7. AGE: 2 yrs. 6 mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Roy Sparks

11. BIRTHPLACE OF FATHER (State or Country): Neb

12. MAIDEN NAME OF MOTHER: Lucy H. Duell

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. S. Hurd
(Address) Payette Idaho

15. Filed Oct 18 1916 Crispin Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 30 1916, to Oct. 4 1916, that I last saw her alive on Oct. 4 1916, and that death occurred on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:
Endocarditis

(Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Avery M. D.
Oct. 5, 1916 (Address) Payette, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	Oct 5 1916

20. UNDERTAKER	ADDRESS
D. N. Adair	Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15641
Registered No. 631

1. PLACE OF DEATH. Registration District No. 61
County of Latah Primary Registration District No. 1011
City of Moscow (or Village), Ida St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin M. Foster

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH April 21 1916
(Month) (Day) (Year)

7. AGE ..... yrs. 6 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Walla Walla

10. NAME OF FATHER Jesse A. Foster

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Mable M. Richardson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse A. Foster
(Address) Walla Walla Wash

15. Filed Oct 20 1916 D. L. Rae Local Registrar
for Carothers

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct. 20 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from only one visit Oct 20 191 , to 191 ,
that I last saw him alive on Oct 20 1916
and that death occurred on the date stated above, at 11-40 M.

The CAUSE OF DEATH* was as follows:
Ileo Colitis (Dysentery)

..... (Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. N. Clarke M. D.
..... 19 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Walla Walla Wash. DATE OF BURIAL Oct-22 1916

20. UNDERTAKER Glen Price ADDRESS Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 61

County of Latah — Primary Registration District No. 1011 — File No. 15542

City of Moscow (No. ....., ... St.) — Registered No. 58

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Conrad John Kesel.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: June 5 (Month) (Day) 1854 (Year)

7. AGE: 62 yrs. 4 mos. [redacted] ds. — IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Conrad Kesel.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Marya Schmidt

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mr Fred Kesel
(Address): Moscow Ida

15. Filed Oct 22 1916 — [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend case 191..., to ..... 191...,
that I ~~last~~ saw him alive on ..... 191...,
and that death occurred on the date stated above, at 1 A M.,
The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Aspra M. D.
Oct 21 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~	DATE OF BURIAL
Moscow	Oct 22 1916

20. UNDERTAKER	ADDRESS
Glass Grice	moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. If UNKNOWN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 15643
Registered No. 59

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Oscar Deitrich Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	~~Married~~ Single

6. DATE OF BIRTH
Nov (Month) 29th (Day) 1888 (Year)

7. AGE
27 yrs. 10 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... musician
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wheaton Minnesota

10. NAME OF FATHER Ole Nelson

11. BIRTHPLACE OF FATHER (State or Country) Norway ~~Bjölstad~~

12. MAIDEN NAME OF MOTHER Audina Bjölstad

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Thes Martinson
(Address) Moscow Ida

15.
Filed Oct 10 1916 S. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
10 - 8 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8 - 8 1916 to 10 - 8 1916, that I last saw h[im] alive on 10 - 7 1916 and that death occurred on the date stated above, at 1.20 P.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis Pulmonary

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno a Dodd M. D.
10-10 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	10/10 1916

20. UNDERTAKER	ADDRESS
Glen Price	Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 15644
Registered No. 60

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Abbott Watkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widower

6. DATE OF BIRTH: Feb. (Month) 14 (Day) 1834 (Year)

7. AGE: 82 yrs. 8 mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Hampshire

10. NAME OF FATHER: Jason D. Watkins

11. BIRTHPLACE OF FATHER (State or Country): New Hampshire

12. MAIDEN NAME OF MOTHER: Phoeby Abbott

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ella M. Stewart
(Address) Moscow Idaho

15. Filed Oct 16 1916 D F Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 15 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1914 - 191..., to Oct 15 1916, that I last saw him alive on Oct 14 1916, and that death occurred on the date stated above, at 5.20 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach

(Duration) yrs. 2 mos. ds.
Contributory (Secondary) Epithelioma of face and neck and organs

(Duration) 6 yrs. mos. ds.

(Signed) D F Rae M. D.
Oct 16 1916 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State ....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Oct 16 1916

20. UNDERTAKER: Glenn Gice — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 15645
Registered No. 67
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mina Philopena French

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: November 28 1847 (Month) (Day) (Year)

7. AGE: 68 yrs. 10 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York (State)

10. NAME OF FATHER: Martin Fischer

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: —— Glick

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Burton L. French
(Address) Moscow, Idaho

15. Filed Oct. 14 1916 J. F. Rae. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1916, to Oct 12 1916, that I last saw her alive on Oct 12 1916, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Cancer of Pancreas

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Joseph Caspary M. D.
Oct 13 1916 (Address) Moscow Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Oct 14 1916

20. UNDERTAKER: Glen O Grice | ADDRESS: Moscow

WRITE PLAINLY, with unfading ink—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 15646
Registered No. 62

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ama Tschantz
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 10 (Day) 1881 (Year)

7. AGE: 35 yrs. 4 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Graber

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Tschantz
(Address) Santhwick Idaho.

15. Filed Oct 22 1916 D. P. Rae, Local Registrar
per Carithers

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. 21st 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 17th 1916, to Oct. 21st 1916, that I last saw her alive on Oct. 21st 1916, and that death occurred on the date stated above, at 4:10 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia.

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Carithers M. D.
Oct 22 1916 (Address) Moscow Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos. 4 days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? Southwick Ida.
Former or usual residence Southwick Id.

19. PLACE OF BURIAL OR REMOVAL: Southwick Idaho
DATE OF BURIAL: Oct 23rd 1916

20. UNDERTAKER: Glen Guile
ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. County Farm St.)

File No. 15647
Registered No. 63
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martin Monson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Not Known (Month) 1 (Day) 860 (Year)

7. AGE: 66 yrs. + mos. ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Carothers
(Address) attend physician Moscow

15. Filed Oct 23 1916 W. H. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March. 1916, to Oct. 12 1916, that I last saw him alive on Oct. 12" 1916, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Tabular Insufficiency (Heart)

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Carothers M. D.
Oct 23 1916 (Address) Moscow, Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 3 mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? Genesee, Id
Former or usual residence Genesee Id

19. PLACE OF BURIAL ~~OR REMOVAL~~: Moscow | DATE OF BURIAL: Oct 23 1916

20. UNDERTAKER: Glen Price | ADDRESS: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 15648
Registered No. 64
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Urquhart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 12 (Day) 1847 (Year)

7. AGE: 69 yrs. 4 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer): farmer.

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: David Urquhart

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Sarah Rockefeller

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Earl Urquhart
(Address) Moscow

15. Filed Oct 6 1916 — J. F. Rae, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1916, to Oct 4 1916, that I last saw him alive on Oct 4 1916, and that death occurred on the date stated above, at 10 10 A.M.

The CAUSE OF DEATH* was as follows:
Myocarditis.

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph Asprey M. D.
Oct 6 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Oct 6 1916

20. UNDERTAKER: Glen O Grice — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15649
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Potlatch

Registration District No. 66
Primary Registration District No. 2145
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Merle Roach

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: 8 (Month) 20 (Day) 1916 (Year)

7. AGE: ..... yrs. 2 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Bruce Roach

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Margrette Murphey

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bruce Roach
(Address) .....

15.
Filed Oct 30 1916
W. J. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 10 (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-28-16, to 10-28-16
that I last saw him alive on 10-28- 1916
and that death occurred on the date stated above, at 6 M.

The CAUSE OF DEATH* was as follows:
Cholera Infantum

..... (Duration) ..... yrs. ..... mos. 9 ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Wyatt M. D.
10-30 1916 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Idaho
DATE OF BURIAL: Oct 31 1916

20. UNDERTAKER: E Anderson
ADDRESS: Potlatch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65
Primary Registration District No. 2145
(No. St.)

File No. 15650
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ed W Elwin Siler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 1 (Day) 1894 (Year)

7. AGE: 22 yrs. 8 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: W A Siler

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Nancy Clark

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Siler
(Address) Palouse Wash

15. Filed Oct. 31 - 1916. D Jm. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Crushing injury of chest caused by auto accident

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D B Harrison M. D.
10/29/ 1916 (Address) Palouse Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Greer — DATE OF BURIAL: Nov 3 1916

20. UNDERTAKER: E Anderson — ADDRESS: Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 65

County of Latah Idaho Primary Registration District No. 2145

File No. 15651

City of ..... (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Rance Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH 1894 Feb 16

(Month) (Day) (Year)

7. AGE 22 yrs. 8 mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Latah County Idaho

10. NAME OF FATHER W. W. Davis

11. BIRTHPLACE OF FATHER (State or Country) Lane County Oregon

12. MAIDEN NAME OF MOTHER Anna E. Fisk

13. BIRTHPLACE OF MOTHER (State or Country) Iowa Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Davis
(Address) Palouse Wash

15. Filed Oct 30 1916 J. M. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Crushing injury caused by auto accident

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D B Harrison M. D.

10/30/1916 (Address) Palouse Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fruse, Idaho	Oct 31 1916
20. UNDERTAKER	**ADDRESS**
F. L. Swim	Garfield

SYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15652

Registered No. .....

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of St. Maries.

2. FULL NAME Julius Nord.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 27 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. Klinsolving
(Address) St. Maries

15. Filed Oct 5 1916 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1916, to Oct-3 1916, that I last saw him alive on Oct 3 1916, and that death occured on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis -
Abscess in leg etc.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Klinsolving M. D.

10/3 1916 (Address) St. Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Marie's — DATE OF BURIAL: Oct 5 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGR. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15653

Registered No. .....

Registration District No. 31

Primary Registration District No. 2049

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Bennewah

City of St Maries

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donald Cox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Dec (Month) 21 (Day) 1911 (Year)

7. AGE: 5 Yrs. 10 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: Charles Cox

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Sadie Jarrean

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Cox

(Address) St Maries

15. Filed Oct. 17 1916 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1916, to Oct 17 1916, that I last saw him alive on Oct 17 1916, and that death occured on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

..... (Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Owen O'Dell M. D.

Oct 17 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Oct 19 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15654

Registered No. .....

1. PLACE OF DEATH.

County of Benewah.

City of St Maries

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tony Lucas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ✓

6. DATE OF BIRTH. ✓ (Month) ✓ (Day) 1 ✓ (Year)

7. AGE: about 30 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Lumber worker

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Austrian

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Oct 20 1916 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1916, to Oct 19 1916, that I last saw h[illegible] alive on Oct 18 1916, and that death occured on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:

Lumyngeal Diphtheria

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L Klorimatt M. D.

Oct 20 1916 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Marie's — DATE OF BURIAL: Oct 19 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St M.

SYMS - YORK CO., PTRS. & BOOKS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15655
Registered No.

1. PLACE OF DEATH.
County of Benewah
City of St Joe
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

2. FULL NAME Baby Rummerfield

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Oct (Month) 5 (Day) 1916 (Year)

7. AGE: — yrs. — mos. 12 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Fred Rummerfield

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Gertie Tibbits

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Rummerfield
(Address) St Joe

15. Filed Oct 23 1916 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1916, to Oct 22 1916 that I last saw h[illegible] alive on Oct 21 1916 and that death occurred on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:

Bronchitis
..... (Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Coeld
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Leete M. D.
Oct 23 1916 (Address) St Joe Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Maries Ida — DATE OF BURIAL: 10/24/1916

20. UNDERTAKER: H. E. Hunt — ADDRESS: St Maries Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 15656
Registered No. .....

1. PLACE OF DEATH.
County of Benewah
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Winter Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 30 (Day) 1916 (Year)

7. AGE: ..... Yrs. 2 Mos. ~ ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): St Maries Ida.

10. NAME OF FATHER: Albert Winter

11. BIRTHPLACE OF FATHER (State or Country): Williamsport Penn.

12. MAIDEN NAME OF MOTHER: Teresa Guadt

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert Winter
(Address) St Maries Ida

15.
Filed ..... 191....
H E Ernst
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1916, to Oct 26 1916, that I last saw ~~him~~ alive on Oct 26 1916 and that death occured on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows: Cholera Infantum

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Owen D Glass M. D.
Oct 26 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Oct 28 1916

20. UNDERTAKER: H E Ernst — ADDRESS: St M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 15657
Registered No. 31

1. PLACE OF DEATH.
County of
City of Ontario
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francisco Hoffman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH. June (Month) 19 (Day) 1841 (Year)

7. AGE: 75 Yrs. 3 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Austria

10. NAME OF FATHER Hlobil

11. BIRTHPLACE OF FATHER (State or Country) Austria

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jacob Hoffman
(Address) Payette Idaho

15. Filed Oct 9 1916 J C Woodward Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) Seventh (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1916, to Oct. 7 1916, that I last saw h. alive on Oct 6 1916, and that death occured on the date stated above, at 11.40 A.M.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency
Pulmonic Insufficency.
(Duration) ? Yrs. mos. ds.
Contributory (Secondary) Interstitial Nephritis
(Duration ? yrs. mos. ds.

(Signed) J. L. McConnell M. D.
Oct 9 1916 (Address) Payette.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: Oct 9 1916

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15658

Registered No. 35

1. PLACE OF DEATH.

County of Canyon

City of Payette

(No. ..... St.)

Registration District No. 4

Primary Registration District No. 1008

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clark Anson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 19 (Day) 1916 (Year)

7. AGE: 1 yrs. 1 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Elmer Anson

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Florence Moss

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs H. J. Barnes

(Address)

15. Filed Oct 23 1916 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1916, to Oct 20 1916 that I last saw h alive on Oct 20 1916 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dio-colitis

(Duration) ..... yrs. ..... mos. 12 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. W. Mc Dowell M.D.

Oct 23 1916 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette (Riverside) | DATE OF BURIAL: Oct 22 1916

20. UNDERTAKER: L N. Barr | ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 558

Registered No. 15659

1. PLACE OF DEATH.

County of Blaine

City of Ores

Registration District No. 59

Primary Registration District No. 2139

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Edward Wyatt.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Jan (Month) 20 (Day) 1851 (Year)

7. AGE: 65 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Juvere Co. Utah

10. NAME OF FATHER: John Wyatt

11. BIRTHPLACE OF FATHER (State or Country): Vt. Burnon

12. MAIDEN NAME OF MOTHER: Butterfield

13. BIRTHPLACE OF MOTHER (State or Country): Vt. Burnon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ben Wyatt

(Address) Ores Idaho

15. Filed 9/25 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/25 1916, to 9-25 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Thrown from runaway wagon. Striking on head. Fracture at base of skull

(Duration) ~~Yrs.~~ mos. 3 hrs

Contributory (Secondary) Compression of Brain

(Duration) ..... yrs. ..... mos. 3 hrs

(Signed) E. W. Fox M. D.

19..... (Address) Ores, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ores, Idaho

DATE OF BURIAL: 9/27 1916

20. UNDERTAKER: H. Silcox

ADDRESS: Ores, Ida

STAR - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2159
(No. ....., ... St.)

File No. 15661
Registered No. .....

1. PLACE OF DEATH.
County of Blaine
City of Hailey
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John J. Bains

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. not known (Month) (Day) 1 (Year)
7. AGE: About 63 yrs. Mos. ds. — Positively — IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep herder
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): not known
10. NAME OF FATHER: not known
11. BIRTHPLACE OF FATHER (State or Country): not known
12. MAIDEN NAME OF MOTHER: not known
13. BIRTHPLACE OF MOTHER (State or Country): not known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....
15. Filed 10/18 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 17 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Hemorrhage from small artery left arm caused by Gun shot wound. Consequent
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
10/18 19 16 (Signed) ..... M. D.
(Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey, Idaho — DATE OF BURIAL: 10/19 1916
20. UNDERTAKER: Ed Leland, acting — ADDRESS: Hailey, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BOKS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2086
(No. , St.)

File No. 15662
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Carskaden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	

6. DATE OF BIRTH: Oct (Month) 10 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Filer Ida

10. NAME OF FATHER: Jim Carskaden

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mabel Lutley

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jim Carskaden
(Address) Filer Ida

15. Filed 10/11 1916 A A Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1916, to Oct 10 1916 that I last saw him alive on Oct 10 1916, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Delayed Asphyxia
~~Not Known~~

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A A Newberry M. D.
10/10 1916 (Address) Filer Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Filer Cemetery | DATE OF BURIAL: 10/11 1916

20. UNDERTAKER: D E Drake | ADDRESS: Filer Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2086
File No. 15663
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Filer (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Clifford Arrasmith

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	S

6. DATE OF BIRTH: Oct. (Month) 31 (Day) 1903 (Year)

7. AGE: 12 yrs. 11 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Earl Arrasmith

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Edna Duncan.

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edna Stroud
(Address) Filer Ida

15. Filed 10/12 1916 A A Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 11 1916, to Oct. 12 1916, that I last saw h/m alive on Oct 12 1916 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. A. Newberry M. D.
19 .... (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Filer Cem.	10/13 1916

20. UNDERTAKER	ADDRESS
F E Drake	Filer Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2086
File No. 15664
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Graybeill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 4 (Day) 1840 (Year)

7. AGE: 76 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Maiden
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: John Graybeill

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Francis Brennen

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D L Graybeill
(Address) .....

15. Filed 10 - 1 1916 C A Newberry Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1916, to Oct 15 1916, that I last saw h[illegible] alive on Oct 14 1916 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation
(Duration) 10 Yrs. mos. ds.
Contributory (Secondary) Dislocation & fracture of hip
(Duration yrs. mos. 19 ds.
(Signed) Frank A Wright M. D.
Nov. 1 1916 (Address) Filer, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Abeline Kansas

19. PLACE OF BURIAL OR REMOVAL: Abeline Kansas — DATE OF BURIAL: Oct 18 1916

20. UNDERTAKER: F E Drake — ADDRESS: Filer

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15665

Registered No. 14

1. PLACE OF DEATH.

County of Lewis

City of Ilo

Registration District No. 60

Primary Registration District No. 2129

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph N. Norman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct. (Month) 21 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farm Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed ..... 191..... R E Dunlap Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1916, to Oct 20 1916, that I last saw him alive on Oct 20 1916, and that death occured on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Bush M. D.

19.... (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery — DATE OF BURIAL: 10/22 1916

20. UNDERTAKER: Star Hdw. Imp. Co. — ADDRESS: Ils Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ROBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15666

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 79

Primary Registration District No. 3156

County of Bannock

City of Pocatello (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy Gillard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. X Aug. 29 1916
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bannock County Ida

10. NAME OF FATHER Frank Gillard

11. BIRTHPLACE OF FATHER (State or Country) Michigan

12. MAIDEN NAME OF MOTHER Georgia Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Gillard
(Address) .....

15. Filed Oct. 23 1916. E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191—, to ——— 191—, that I last saw her alive on Oct 23 1916, and that death occured on the date stated above, at 10.30 A. M.

The CAUSE OF DEATH* was as follows:

Acute bronchus pneumonia

(Duration) — Yrs. — mos. 2 ds.

Contributory (Secondary) .....
(Duration ... yrs. ... mos. ... ds.

(Signed) S. T. Powell M. D.

10.25 1916. (Address) Bannock County Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Bannock County Ida — DATE OF BURIAL Oct 23 1916

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15668

Registered No. .....

1. PLACE OF DEATH.

County of Bonner

Registration District No. .....

Primary Registration District No. 7156.

City of Bonners Ferry (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Opal Patrick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 23 (Day) 1916 (Year)

7. AGE ..... Yrs. 9 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bonners Ferry Ida

10. NAME OF FATHER David Patrick

11. BIRTHPLACE OF FATHER (State or Country) West Virginia

12. MAIDEN NAME OF MOTHER Josephine Doyle

13. BIRTHPLACE OF MOTHER (State or Country) South Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dave Patrick

(Address) Sand Point Ida

15. Filed Sept. 27 1916. E. E. Fox Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 27th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at 6.30 a. M.

The CAUSE OF DEATH* was as follows:

Whitmore - Sudden death.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: 9/28 1916

20. UNDERTAKER: John J. Moore — ADDRESS: Bonners Ferry Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79.
Primary Registration District No. 2156.
File No. 15669
Registered No. .....

1. PLACE OF DEATH.
County of Boundary
City of Meadow Creek
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nettie Merchant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 29 (Day) 1864 (Year)

7. AGE: 46 Yrs. 11 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): /

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Bryas Diamond

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Sarah Voght

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Merchant
(Address) Meadow Creek

15.
Filed Sept. 17 1916
E E Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1914, to Sept. 16 1916, that I last saw her alive on Sept. 16 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial nephritis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Faucett M. D.
Sept. 20 19 16 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: 9/18 1916

20. UNDERTAKER: John D. Maute — ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 3156.
(No. ..... St.)

File No. 15670
Registered No. .....

1. PLACE OF DEATH.
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna P. Downing

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 7 (Day) 1874 (Year)

7. AGE: 42 Yrs. 2 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): U. S.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) W. H. Downing

15. Filed Sept. 5th 1916. E. E. Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 22 1916, to Sept. 4 1916, that I last saw h[illegible] alive on Sept. 4 1916, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Brights - Interstitial nephritis
(Following pregnancy)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Myocarditis
..... (Duration ..... yrs. 1 mos. ..... ds.
(Signed) E. E. Fry M. D.
9/5/1916 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida. DATE OF BURIAL: 9/7 1916

20. UNDERTAKER: John T. Moore ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15671
Registered No. .....

1. PLACE OF DEATH.
County of Canyon Registration District No. 79.
City of Boise (No. ..... St.) Primary Registration District No. 2186.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Westergreen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 21 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed July 21st 1916. E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 20th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18th 1916, to July 20th 1916, that I last saw him alive on July 19th 1916, and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Fracture Spine - cervical.
(Accidental)

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry, M. D.

7/21 1916 (Address) Boise Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pioneer Cemetery Idaho — DATE OF BURIAL: July 20 1916

20. UNDERTAKER: J. T. Moore — ADDRESS: Boise Ferry Ida

BYNS - YORK CO., PTRS. & BORS. 24854

WRITE, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
... of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15672

Registered No. .....

1. PLACE OF DEATH.

County of Bonner

City of Bonners Ferry (If outside limits, give township) St.)

Registration District No. 39

Primary Registration District No. 3156

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence E. Porter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 10th (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bonners Ferry Idaho

10. NAME OF FATHER Peter J. Porter

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Alice Gilland

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F Porter

(Address) Bonners Ferry Ida

15. Filed July 11 - 1916. E. E. Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 11th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1916, to July 11 - 1916, that I last saw h.r alive on July 11 - 1916 and that death occured on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Cerebral hemmorhage -
(Convulsions)

.....(Duration) ..... Yrs. ..... mos. ..... da.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

7/11 1916 (Address) Bonners Ferry, Ida -

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Bonners Ferry Ida DATE OF BURIAL July 12 1916

20. UNDERTAKER Hall Porter ADDRESS B. Ferry Ida

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RESERVED FOR BINDING

MAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRD - YORK CO., PTRS. & BOKS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15673

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 79

County of Kootenai Primary Registration District No. 215-6.

City of Bonners Ferry (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur James McGinnis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. July (Month) 5th (Day) 1867 (Year)

7. AGE 48 Yrs. 8 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Locomotive engineer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Maine

10. NAME OF FATHER Bernard McGinnis

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Margaret Flaherty

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret L. McGinnis

(Address) 534 Royal St. Hillyard, Wash.

15.

Filed July 5th 1916. E. E. Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 3rd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at 2-10 A. M.

The CAUSE OF DEATH* was as follows:

Drowning - accidental

(Coroners record)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL Hillcrest | DATE OF BURIAL 7/6 1916

20. UNDERTAKER John S. Moore | ADDRESS Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15674

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 79

Primary Registration District No. 315-6

County of Boundary

City of Bonners Ferry (If not in city or village give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edmund Templeton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 21 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. F. Hays

(Address) Hillyard Wash

15.

Filed July 5 - 1916. E. E. Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH* was as follows:

Drowning - accidental

(Jam Wrecks)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Spokane Wn.

DATE OF BURIAL: 9/6 1916

20. UNDERTAKER: John J. Moore

ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24659

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee
City of Silver
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 43
Primary Registration District No. 2120.
(No. ....., ... St.)

File No. 15675
Registered No. 35
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Nellie Annand.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female.	White	Widowed.

6. DATE OF BIRTH
June (Month) 1st (Day) 1845 (Year)

7. AGE
71 yrs. 5 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland.

10. NAME OF FATHER Samuel Deales.

11. BIRTHPLACE OF FATHER (State or Country) Ireland.

12. MAIDEN NAME OF MOTHER Rachel Deales.

13. BIRTHPLACE OF MOTHER (State or Country) Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charlotte E Greb.
(Address) Caldwell, Idaho.

15.
Filed October, 29, 1916. W. H. Schumacher M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
October (Month) — 24 (Day) — 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October, 17, 1916, to October, 24, 1916 that I last saw h.er alive on October, 24, 1916 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Acute pericarditis following acute articular rheumatism.

.....(Duration)....yrs....mos. 1 3 ds.
Contributory (Secondary) Old age.
.....(Duration)....yrs....mos....ds.

(Signed) W. H. Schumacher M. D.
Oct. 24, 1916 (Address) Silver City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Masonic cemetery Silver City	Oct 27th 1916

20. UNDERTAKER John Keefe. ADDRESS Silver City

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

15677

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 58
Primary Registration District No. 2138
File No.
Registered No.

1. PLACE OF DEATH.
County of Blaine
City of Fairfield
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm E Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
(Month) (Day) 1871 (Year)

7. AGE
45 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mail Carrier
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Walter H Fullis
(Address) Tampa Idaho

15. Filed Oct 11 1916 Anna Hatfield Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1916, to 1916, that I last saw h. alive on Oct 10 1916 and that death occured on the date stated above, at 6:50 P.M.

The CAUSE OF DEATH* was as follows:
Killed by lightning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Aatigg M. D.
19.. (Address) Fairfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida
DATE OF BURIAL: 191..

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should state CAUSE OF DEATH in plain terms, so that it may be properly classed. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006.
File No. 15678
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fredrick W Young

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. June (Month) 2nd (Day) 1869 (Year)
7. AGE: 47 Yrs. ..... Mos. 4 ds. 2
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Manager Ice Plant
(b) General nature of industry, business, or establishment in which employed (or employer): Retail Ice Merchant
9. BIRTHPLACE (State or Country): Caledonia Ontario Canada
10. NAME OF FATHER: Charles Young
11. BIRTHPLACE OF FATHER (State or Country): Caledonia Ontario Canada
12. MAIDEN NAME OF MOTHER: Annie Thompson
13. BIRTHPLACE OF MOTHER (State or Country): Caledonia Ontario Canada
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lillie E Young
(Address) Nampa Idaho
15. Filed Nov 6 1916 Anna Warfield Local Registrar

BYMM - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 4 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 18 1916, to Nov 4 1916, that I last saw him alive on Nov 4 1916, and that death occured on the date stated above, at 1:15 P.M.
The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis
(Duration) 3 Yrs. - mos. - ds.
Contributory (Secondary) - (Duration - yrs. - mos. - ds.
(Signed) F. B. Smith M. D.
11/5 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho — DATE OF BURIAL: 11-6 1916
20. UNDERTAKER: Fred K. Robinson — ADDRESS: Nampa Ida

6 OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Nampa

Registration District No. 1006.

Primary Registration District No. .....

(No. ....., ... St.)

File No. 15679

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josephine J. Snyder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fem	White	Widow

6. DATE OF BIRTH.

Mar (Month) 2 (Day) 1834 (Year)

7. AGE

82 Yrs. 8 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.. Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Ohio

10. NAME OF FATHER William Combe

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER Grace Trick

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. N. Frame

(Address) Nampa Idaho

15.

Filed Nov 7 1916 Anna Hatfield Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov (Month) 4th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at 1.30 P M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) Many Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. C. Robinson M. D.

11/7 1916 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Nyoda Iowa

DATE OF BURIAL ..... 191...

20. UNDERTAKER Fred K Robinson

ADDRESS Nampa Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

15680

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 1006

County of Canyon

City of Nampa (No. ..... St.)

File No. .....

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Caramella Stahl

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word)
Fem	White	Married

6. DATE OF BIRTH. May (Month) 4 (Day) 1870 (Year)

7. AGE 46 Yrs. 6 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Evansville Ind.

10. NAME OF FATHER Dr. Rusk

11. BIRTHPLACE OF FATHER (State or Country) Evansville Ind

12. MAIDEN NAME OF MOTHER Sophie Rusk

13. BIRTHPLACE OF MOTHER (State or Country) Evansville Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J G Stahl

(Address) Nampa Ida

15. Filed Nov 10 1916 Ames Hayes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at death, 191..., to Nov 9 1916, that I last saw h... alive on ..... 191..., was dead when I called - and that death occured on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Had dropsy with one affection of heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

42 (Duration 12 yrs. ..... mos. ..... ds.

(Signed) J H Murray M. D.

11/10 1916. (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rohlerlawn — DATE OF BURIAL Nov 11 1916

20. UNDERTAKER C B Shellabarger — ADDRESS Nampa Ida

SHOULD STATE CAUSE OF DEATH IN PLAIN ENGLISH. Fill in all items, if any, and if none, write NONE. Space for OCCUPATION is very important. See instructions on back of certificate.

SVMB - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Nampa

Registration District No.

Primary Registration District No. 1006

(No. ..... St.)

File No. 15681

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wong Yen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Chinese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 50 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laundryman

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Dan Kuan

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dong Yuen Long

(Address) Nampa Idaho

15. Filed Oct 18 1916 Anna Hatfield Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1916, to Oct 17 1916, that I last saw h— alive on Oct 17 1916, and that death occured on the date stated above, at 11 o'c M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

4 wks (Duration) ..... Yrs. 1 mos. 28 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Clyde Walsh M. D.

Oct 18 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Ave

DATE OF BURIAL: 10/19 1916

19. UNDERTAKER: Stud H Robinson

ADDRESS: Nampa

of OCCUPATION is very important. See instructions on back of certificate.

BYRNS - YORK CO., PTRS. & STRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 15682
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Mc Kelvey.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
(Month) x (Day) x 1 x (Year)

7. AGE: about 40 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: No information could be obtained

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anna Hatfield
(Address) Nampa Ida

15. Filed Oct 18 1916 Anna Hatfield
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 8 1916, to Oct 16 1916, that I last saw him alive on Oct 16 1916, and that death occured on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
Don't know,
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H. I. Rosa M. D.
Oct 8 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rosedale — DATE OF BURIAL: Oct 20 1916

20. UNDERTAKER: F. R. Robinson — ADDRESS: Nampa Ida

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36

Primary Registration District No.

File No. 15683

Registered No.

1. PLACE OF DEATH.

County of Twin Falls.

City of Hansen

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosa Mildred Evans

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June 21 (Month) (Day) 1891 (Year)

7. AGE. 25 Yrs. 3 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Joseph C. Hankins

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Emily Baker

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie M. Biller

(Address) Hansen Idaho

15.

Filed ..... 191....

J. N. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1916, to Oct 6 1916, that I last saw her alive on Oct 5 1916 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Davis M. D.

Oct. 6 1916 (Address) Kimberly, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the state.....yrs. 4 mos.....days

Where was disease contracted if not at place of death? Hansen

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Oct. 7 1916

20. UNDERTAKER: C. Crosby — ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & ENGS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 15684
Registered No. 10

1. PLACE OF DEATH.
County of Bannock
City of Chesterfield (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rebecca Ann Dawson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: f
4. COLOR OR RACE: w
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) Oct (Day) 9 (Year) 1916

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 4 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Austin Dawson

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Adah Rice

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Austin Dawson
(Address) Chesterfield

15.
Filed 10/20 1916 D. J. Smith Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Oct (Day) 9 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1916, to Oct 9 1916, that I last saw h[illegible] alive on Oct 9 1916, and that death occured on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Compression due to prolonged labor

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. J. Smith M. D.

10/20 1916 (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chesterfield
DATE OF BURIAL: 10/11 1916

20. UNDERTAKER: none
ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15686

Registered No. 26

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

Registration District No. 19

Primary Registration District No. 2015

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ursula P Dunnay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 14 (Day) 1883 (Year)

7. AGE: 34 Yrs. 4 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... Home Wife

9. BIRTHPLACE (State or Country) Alabama.

10. NAME OF FATHER Jno T Wilkins

11. BIRTHPLACE OF FATHER (State or Country) Georgia

12. MAIDEN NAME OF MOTHER Virginia Wilkins

13. BIRTHPLACE OF MOTHER (State or Country) Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. T. Wilkins

(Address) Rupert Ida

15.

Filed 10-14 1916

E. T. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-1 1916, to 10-13 1916, that I last saw h—1 alive on 10-13 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Septicemia, following Abortion

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Abortion

..... (Duration) 4 yrs. ..... mos. ..... ds.

(Signed) E. T. Elmore M. D.

10/16 1916 (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake — DATE OF BURIAL: 10-15 1916

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 19

Primary Registration District No. 2015

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15687

Registered No. 27

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Haynes.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.

Sept (Month) 7 (Day) 1884 (Year)

7. AGE

32 Yrs. 1 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer + stockraising

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Cooper Utah.

10. NAME OF FATHER: George Haynes

11. BIRTHPLACE OF FATHER

(State or Country) England.

12. MAIDEN NAME OF MOTHER: Louisa Johnson.

13. BIRTHPLACE OF MOTHER

(State or Country) Mountain Green Morgan Co Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora Haynes

(Address) Rupert Ida.

15.

Filed 11-10 1916

E. K. Elmore
Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1916, to Oct 20 1916, that I last saw h— alive on Oct 20 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary)

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) E. K. Elmore M. D.

(Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Ida.

DATE OF BURIAL: 10/25/1916

20. UNDERTAKER: [illegible]

ADDRESS: Burley Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 19

Primary Registration District No. 2015

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15688

Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna E. Mitchell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 10 (Day) 1879 (Year)

7. AGE: 37 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Schoolteacher

9. BIRTHPLACE (State or Country): Llanidloes Wales.

10. NAME OF FATHER: Richard Higgs

11. BIRTHPLACE OF FATHER (State or Country): Llanidloes Wales

12. MAIDEN NAME OF MOTHER: Margaret Brown

13. BIRTHPLACE OF MOTHER (State or Country): Llanidloes Wales.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. W. E. Mitchell

(Address) Rupert, Ida.,

15.

Filed 11 — 10 1916

E. H. Elmore
Local Registrar

SYMS - YORK CO., PTRS. & ROBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1916, to Oct 22 1916, that I last saw h-r alive on Oct 21 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Embolism of Heart.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature Birth

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Elmore M. D.

10-22 1916 (Address) Rupert.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Ida. DATE OF BURIAL: 10/23 1916

20. UNDERTAKER: Rupert Undertaking Co. ADDRESS: Rupert Ida.

D. Galloway.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 117
Primary Registration District No. 2191
(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15689
Registered No. 1414

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Arnold Davis

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 8 (Day) 1915 (Year)

7. AGE: 1 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Idaho

10. NAME OF FATHER: H. V. Davis

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Iva Irene Conners

13. BIRTHPLACE OF MOTHER (State or Country): Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. V. Davis
(Address) Burley Ida

15. Filed Oct. 9th 1916. Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 8th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 4th 1916, to Oct. 8 1916, that I last saw h..... alive on Oct. 7th 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Gastroenteritis

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
Oct 9 1916 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Cemetery — DATE OF BURIAL: Oct 10 1916

20. UNDERTAKER: Robert W Watt — ADDRESS: Burley Ida

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 15690
Registered No. 146

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alma Laverne Neeley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 29 (Day) 1916 (Year)

7. AGE: 0 Yrs. 0 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Ida

10. NAME OF FATHER: Edmer Neeley

11. BIRTHPLACE OF FATHER (State or Country): Franklin Idaho

12. MAIDEN NAME OF MOTHER: Laverne Orchard

13. BIRTHPLACE OF MOTHER (State or Country): Lewiston - Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edmer Neeley
(Address)

15. Filed Oct 6th 1916. D. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 6th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29th 1916., to Oct. 6th 1916., that I last saw him alive on Oct 5th 1916., and that death occured on the date stated above, at 2 p. M.

The CAUSE OF DEATH* was as follows:
Premature - child

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
10-6 1916. (Address) Burley, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burley Cemetery	Oct 7 1916
20. UNDERTAKER	ADDRESS
Robert W Watt	Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15091

Registered No. 143

1. PLACE OF DEATH.

County of Cassia

City of Burley

(No. ....., ... St.)

Registration District No. 117

Primary Registration District No. 2196

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy Wise

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH. July (Month) 4 (Day) 1916 (Year)

7. AGE ..... Yrs. 0 Mos. 2 ds. 28

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Burley Ida

10. NAME OF FATHER P. B. Wise

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Mary Ridge

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. B. Wise

(Address) Burley Ida

15. Filed Oct. 3rd 1916 Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 2nd (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 23 1916, to Oct. 2nd 1916, that I last saw her alive on Oct. 2nd 1916, and that death occured on the date stated above, at 8:15 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) Yrs. 0 mos. 2 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.

10-3 1916 (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley, Ida. DATE OF BURIAL: 10-5 1916

20. UNDERTAKER: R. W. Watt ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 15692
Registered No. 140

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mable Mary Woodhouse.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 11th. (Day) 1916. (Year)

7. AGE: ....Yrs....Mos. 5 ds.
IF LESS than 1 day how many ....hrs. or ....min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Ida.

10. NAME OF FATHER: Wilford W. Woodhouse.

11. BIRTHPLACE OF FATHER (State or Country): Lehi Utah.

12. MAIDEN NAME OF MOTHER: Laura Cook.

13. BIRTHPLACE OF MOTHER (State or Country): Wellington Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wilford W. Woodhouse
(Address) Burley Idaho

15.
Filed Oct. 17th 1916. Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 16 (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 11th 1916., to Oct. 16th 1916., that I last saw her alive on Oct. 14th 1916., and that death occured on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:
Pneumonia, Premature Birth

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)
(Duration ....yrs. ....mos. ....ds.

(Signed) J. C. Patterson M. D.
10-17 1916 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pella Ida. DATE OF BURIAL: Oct 17 1916.

20. UNDERTAKER: L. Gallogly ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 15694
Registered No. 138

1. PLACE OF DEATH.
County of Cassia
City of Hazel
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Shepherd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. 25 1886
(Month) (Day) (Year)

7. AGE: 32 Yrs. ..... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: W. H. Avery

11. BIRTHPLACE OF FATHER (State or Country): Deceased

12. MAIDEN NAME OF MOTHER: Elyza Shepherd

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Wm Avery
(Address): Burley, Ida.

15. Filed Oct-30th 1916. Dr. J. L. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 30th 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 26th 1916, to Oct. 30th 1916, that I last saw her alive on Oct. 29th 1916, and that death occured on the date stated above, at 1. P. M.

The CAUSE OF DEATH* was as follows:
Pesitonitis, Puerperal,
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. L. Patterson M. D.
10-30 1916 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hazel, Ida. DATE OF BURIAL: 11-2 1916.

20. UNDERTAKER: Irene ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 15695
Registered No. 142

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Ethel Greene.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Jan (Month) 11 (Day) 1911 (Year)

7. AGE
5 Yrs. 9 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. At home.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Boise Ida.

10. NAME OF FATHER: John Allen Greene.

11. BIRTHPLACE OF FATHER
(State or Country) Brooklin Iowa

12. MAIDEN NAME OF MOTHER: Lena Florence Montgomery.

13. BIRTHPLACE OF MOTHER
(State or Country) Baker City Oregon.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Allen Greene
(Address) Burley Ida.

15.
Filed Oct. 18th 1916. Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1916, to Oct 16th 1916, that I last saw h er alive on Oct 16 1916, and that death occured on the date stated above, at 10.30 A.M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach
(Duration) Don't know Yrs. mos. ds.
Contributory (Secondary) Don't know
(Duration) yrs mos. ds.
(Signed) C. J. Story M. D.
19 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Oct 19 1916.

20. UNDERTAKER: L. B. Gallagher ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24053

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15696

Registered No. 148

1. PLACE OF DEATH.

Registration District No. 117

Primary Registration District No.

County of Cassia

City of Burley (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin L. Rudolph.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 9 (Day) 1890 (Year)

7. AGE: 26 Yrs. 6 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retail Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Right Co. Minn.

10. NAME OF FATHER John B. F. Rudolph.

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Mary Kuhnley.

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. F. Rudolph
(Address) Burley Ida.

15. Filed Oct. 6th 1916 Dr. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 6th (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 5th 1916., to Oct. 6th 1916., that I last saw h[illegible] alive on Oct. 6th 1916., and that death occured on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:
Pericarditis

(Duration) Yrs. 1½ mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
10-6 1916 (Address) Burley, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grandjunction Colo. DATE OF BURIAL: Oct 8th 1916

20. UNDERTAKER: [illegible] Gallogly ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196

File No. 15697

County of .....

City of ..... (No. ....., ... St.)

Registered No. 147

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm. John Teasdale.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Married

6. DATE OF BIRTH. Aug. (Month) 28 (Day) 1859 (Year)

7. AGE 57 Yrs. 1 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Miner.

9. BIRTHPLACE (State or Country) N. Y.

10. NAME OF FATHER Teasdale.

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Irene Lee
(Address) Burley Ida.

15. Filed Oct. 23rd 1916 Dr. J. C Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1916, to Oct 22 - 1916, that I last saw him alive on Oct 22 1916, and that death occured on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows: Mitral regurgitation

Several (Duration) Yrs. mos. ds.

Contributory (Secondary) Unknown

Ascitis (Duration) Yrs. mos. ds.

(Signed) J. Jennings M. D.

19..... (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burley Ida	10/24/1916
20. UNDERTAKER L B Talbot	ADDRESS Burley Ida.

BYRNS - YORK CO., PTRS. & BKBS. 24688

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62
Primary Registration District No. 2742

File No. 15698
Registered No. 1

1. PLACE OF DEATH.
County of Latah
City of Genesee (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Angeline Fuller

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	Caucasian	widowed

6. DATE OF BIRTH February (Month) 23 (Day) 1839 (Year)

7. AGE 77 yrs. 8 mos. 1 ds. (Uppsvy) IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work House wife retired 7yrs.
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Zadok Brouson

11. BIRTHPLACE OF FATHER (State or Country) Can't tell

12. MAIDEN NAME OF MOTHER Jennett Benjamin old fashion spelling

13. BIRTHPLACE OF MOTHER (State or Country) Can't tell

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. B. F. Inochel
(Address) Genesee, Idaho

15.
Filed Oct 25 1916 W. H. Eheen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw her alive on ..... 191...
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows: Probably Chronic Nephritis died very Patient Fueld after duste

2 (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. T. Greeny M. D.
Oct 25 1916. (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Foot Gen	Oct 27 1916

20. UNDERTAKER	ADDRESS
J. C. Lambert	Genesee Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15700

Registered No. 720

1. PLACE OF DEATH.

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2135

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Strong

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	single

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1 (Year)

7. AGE

3 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Idaho.

10. NAME OF FATHER Lewis Strong

11. BIRTHPLACE OF FATHER

(State or Country) Missouri

12. MAIDEN NAME OF MOTHER Ellen Grace

13. BIRTHPLACE OF MOTHER

(State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Frank

(Address) Sandpoint

15.

Filed Oct 6 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 6 1916

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1916 to Oct 6 1916,

that I last saw h.. alive on Oct 6 1916,

and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Acute infection of ankle

.....

.....

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Injury foot

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.

Oct 7 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Idaho	Oct 7 1916

20. UNDERTAKER	ADDRESS
E M Brown	Co.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78 Part
Primary Registration District No. 2153
File No. 15701
Registered No. 721

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Neal McIntyre.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 5 (Day) 1865 (Year)

7. AGE 51 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Car Inspector.
(b) General nature of industry, business, or establishment in which employed (or employer)..... N.P.

9. BIRTHPLACE (State or Country) Ireland.

10. NAME OF FATHER Sam McIntyre

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER M——

13. BIRTHPLACE OF MOTHER (State or Country) Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed Sept 14 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1916, to Sept 13 1916, that I last saw h. m. alive on Sept 12 1916, and that death occured on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach

(Duration) ✓ Yrs. ✓ mos. ✓ ds.
Contributory (Secondary) ✓
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. F. Payne M. D.
19..... (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sandpoint Ida — DATE OF BURIAL 9/15 1916

20. UNDERTAKER E M Brown — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78 St.
Primary Registration District No. 2153
File No. 15702
Registered No. 932

1. PLACE OF DEATH.
County of Bonner
City of Sand Point (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. M. Parks.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH. Feb (Month) 11 (Day) 1874 (Year)
7. AGE: 42 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Section Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Georgia
10. NAME OF FATHER: J. Parks.
11. BIRTHPLACE OF FATHER (State or Country): Ga.
12. MAIDEN NAME OF MOTHER: Mattie Lockhear
13. BIRTHPLACE OF MOTHER (State or Country): Ga.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) mrs Barbara Parks
(Address) .....
15. Filed Oct 13 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1916, to Oct 17 1916, that I last saw him alive on Oct 17 1916, and that death occured on the date stated above, at 1.15 P.M.
The CAUSE OF DEATH* was as follows:
Gunshot wound -
..... (Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. P. Staeheline M. D.
11/6 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida
DATE OF BURIAL: 10/14 1916
20. UNDERTAKER: E M Brower.
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15703

Registered No. 923

1. PLACE OF DEATH.

County of Bonner

City of Sandpoint

Registration District No. 28

Primary Registration District No. 2153

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herman F. Lane

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. 8 (Month) 1 (Day) 1 (Year)

7. AGE: ....Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Herman Lane

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Adel Clapp

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Lane

(Address) Sand Point Ida

15. Filed Sept 22 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21 1916, to Sept 21 1916, that I last saw him alive on Sept 21 1916, and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

Gastro Enteritis

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) C. P. Swarthwout M. D.

11/6 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida — DATE OF BURIAL: Sept 22 1916

20. UNDERTAKER: C M Brown — ADDRESS: Sd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

STAR - YORK CO., PTRS. & BKBS. 24859

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78 Dr Moore
Primary Registration District No. 2755
(No. .... St.)

File No. 15704
Registered No. 725

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ben Howard Oscar.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W —
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 13 (Day) 1900 (Year)

7. AGE: 15 Yrs. 10 Mos. [illegible] ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: H. P. Oscar

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Emma Meltes

13. BIRTHPLACE OF MOTHER (State or Country): Wis —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs H. P. Oscar
(Address) Sandpoint.

15. Filed Oct 28 1916 M McKinnon Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1916, to Oct 27 1916, that I last saw him alive on Oct 26 1916, and that death occured on the date stated above, at 3:10 M.

The CAUSE OF DEATH* was as follows:

~~Syphilitic Gummata~~
~~of the cerebrum~~
Acute cerebral Meningitis
(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Syphilitic Gummata of cerebrum
(Duration 16 yrs. ..... mos. ..... ds.

(Signed) W. Fannin Smart M. D.
19 ..... (Address) 10-27-16 Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sand Point Ida. DATE OF BURIAL: 10/30 1916

20. UNDERTAKER: E M Brown ADDRESS: S P.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Hill City
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5-8
Primary Registration District No. 2138
(No. ....., ... St.)

File No. 15705
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas W Ruby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 12 (Day) 1854 (Year)

7. AGE: 62 yrs. 1 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri Iowa

10. NAME OF FATHER: James P Ruby

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Amy Woods

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Ruby
(Address) Hill City Ida

15. Filed 9-2 1916 D O Higgs Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10th 1916, to ..... 191..., that I last saw h[illegible] alive on Sept 10th 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Bulbar Paralysis

(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Paralysis Agitans
(Duration) 10 yrs. ..... mos. ..... ds.
(Signed) O E Bloom M. D.
9-16 1916 (Address) Hill City Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hill City
DATE OF BURIAL: 9-16 1916

20. UNDERTAKER: Fay Mansell
ADDRESS: Fairfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

Dr Boyd

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls,
City of " "
(No. ....., ... St.)

Registration District No 37
Primary Registration District No 1085
File No. 15706
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo B Moran

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. December 27 1864
(Month) (Day) (Year)

7. AGE: 51 Yrs. 9 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Jno. Moran

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed 10 3 1916 — John F Cavanaugh, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1916, to Oct 3" 1916, that I last saw him alive on Oct 2 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Peritonitis
.....
.....
.....(Duration) .....Yrs. .....mos. 3 ds.

Contributory (Secondary) .....
.....(Duration .....yrs. .....mos. .....ds.

(Signed) Jno Boyd M. D.
Oct 3 1916 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ REMOVAL: Heyburn Ida — DATE OF BURIAL: 10-3 1916

20. UNDERTAKER: Chas J. Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 10 80
File No. 15708
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Widower

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 52 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Unknown
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): France

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Probably France

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Probably France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Twin Falls County Nurse
(Address) Twin Falls Ida

15.
Filed 10 19 1916
John F Coughlin
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1916, to Oct 16 1916, that I last saw him alive on Oct 16 1916, and that death occured on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:
Sarcoma of neck

(Duration) Yrs. 4 mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Weaver M. D.
19..... (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 10-17 1916

20. UNDERTAKER: J Crosby
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15709

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of .....

Registration District No. 37

Primary Registration District No. 1085

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaiah Wheeler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH. Nov. (Month) 11 (Day) 1866 (Year)

7. AGE: 49 Yrs. 11 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Traveling Colonization Agt.

(b) General nature of industry, business, or establishment in which employed (or employer): U.P.R.R. Co.

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Dont know.

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Smith

(Address) Room 112, Up. Bldg. Omaha Nebraska

15. Filed 10 20 1916

John F. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17th 1916, to Oct 17th 1916, that I last saw h.. alive on Oct 17th 1916 and that death occured on the date stated above, at 11.15 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

..... (Duration) ..... Yrs. ..... mos. 30 minutes ds.

Contributory (Secondary) Recurrent indigestion

..... (Duration 3 yrs. ..... mos. ..... ds.

(Signed) Duncan E. Alexander M. D.

10/19 1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cerro Gordo Ill — DATE OF BURIAL ..... 191...

20. UNDERTAKER: Freeman & Eaves — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15710
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls Registration District No. 37
City of Rock Creek (No. ....., ... St.) Primary Registration District No. 2585

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Nancy Gwinn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug. 28 (Month) (Day) 1859 (Year)

7. AGE: 57 Yrs. 1 Mos. 17 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Harvy Mc Gee

11. BIRTHPLACE OF FATHER (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: Malinda Abbott

13. BIRTHPLACE OF MOTHER (State or Country): West. Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jas B Gwinn
(Address) Murtaugh Ida

15. Filed 10 19 1916 John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 15th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 14 1916, to ..... 191..., that I last saw her alive on Oct 14 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis

(Duration) Dont know Yrs. ..... mos. ..... ds.
Contributory (Secondary) Uremic Coma
(Duration ..... yrs. ..... mos. 1 ds.

(Signed) C. D. Weaver M. D.
19..... (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Oct 16 1916

20. UNDERTAKER: C J Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15711
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Wash
City of Cambridge
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Coste

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 2 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Chas Coste

11. BIRTHPLACE OF FATHER (State or Country) Wyoming

12. MAIDEN NAME OF MOTHER Mina Hallett

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Surgeon Hopper
(Address) Cambridge Ida

15. Filed Nov 11 1916. C E Schmidt Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1916, to Nov 8 1916, that I last saw h.. alive on Nov 8 1916, and that death occured on the date stated above, at 5A M.

The CAUSE OF DEATH was as follows:
Atelectasis
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Prematurity
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Surgeon Hopper M. D.
19..... (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho — DATE OF BURIAL: Nov 9 1916

20. UNDERTAKER: Jas Hudelson — ADDRESS: Cambridge Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15712

Registered No. .....

1. PLACE OF DEATH.

County of Washington

City of Cambridge

(No. ....., ... St.)

Registration District No. 88

Primary Registration District No. 2164

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ellen Edwards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1842 (Year)

7. AGE: 74 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: E Jewell

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Bennett

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Jewell

(Address) Cambridge, Idaho

15. Filed Nov 1 1916 C C Schmutz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Rupture of Gall bladder

(Duration) 4 Yrs. 3 mos. 10 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Simeon Hopper M. D.

19..... (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho — DATE OF BURIAL: Oct 18 1916

20. UNDERTAKER: Jas Hendlawn — ADDRESS: Cambridge Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15714
Registered No.

1. PLACE OF DEATH.
County of Washington
City of Cambridge
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 55
Primary Registration District No. 2164

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Morris N. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 17 (Day) 1916 (Year)

7. AGE: Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Salubria Idaho

10. NAME OF FATHER Chas Smith

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Jannie McGinnis

13. BIRTHPLACE OF MOTHER (State or Country) Ills

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas Smith
(Address) Salubria Idaho

15. Filed Nov 1 1916 C E Schmutz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25 1916, to Oct 10 1916, that I last saw him alive on Oct 10 1916, and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Cholera Infantum

(Duration) ..... Yrs. ..... mos. 16 ds.
Contributory (Secondary) Malnutrition

(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C E Schmutz M. D.
Oct 19 16 (Address) Cambridge Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Salubria Idaho — DATE OF BURIAL: Oct 11 1916

20. UNDERTAKER: Jas Sundelson — ADDRESS: Cambridge Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15715

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Cambridge

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 88

Primary Registration District No. 2164

2. FULL NAME Baby Button

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 6 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Washington Co Ida.

10. NAME OF FATHER Jas H Button

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Mary Brown

13. BIRTHPLACE OF MOTHER (State or Country) Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas H Button

(Address) Goodrich Ida

15. Filed Nov 1 1916 C E Schmunk Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6 1916, to Nov 9 1916, that I last saw her alive on Nov 9 1916, and that death occured on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Schmunk M. D.

Nov 9 1916. (Address) Cambridge Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Goodrich Ida — DATE OF BURIAL: Nov 10 1916

20. UNDERTAKER: Jas Wadelson. — ADDRESS: Cambridge Ida

SVMB - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 88
Primary Registration District No. 2164
(No. ....., ... St.)

File No. 15716
Registered No. .....

1. PLACE OF DEATH.
County of Washington
City of Cambridge
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Simeon C Hopkey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 24 (Day) 1843 (Year)

7. AGE: 73 Yrs. 3 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Jacob Ader

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Susan C Ader

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Simeon Hopkey
(Address) Cambridge Ida

15. Filed Nov 1 1916 C C Schultz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1916, to Oct 6 1916, that I last saw h.r alive on Oct 6 1916, and that death occured on the date stated above, at 7 4 M.

The CAUSE OF DEATH* was as follows:
Acute Bronchitis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Simeon Hopkey M. D.
10/6 1916 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge — DATE OF BURIAL: Oct 8 1916

20. UNDERTAKER: J A Hudelson — ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 88
Primary Registration District No. Local 2164
File No. 15717
Registered No. ____

1. PLACE OF DEATH.
County of Washington
City of Cambridge
(No. ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Hull Hall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
June (Month) 20 (Day) 1894 (Year)

7. AGE
22 Yrs. 3 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)... Co

9. BIRTHPLACE
(State or Country) Ada County Ida

10. NAME OF FATHER: Wolf Hall

11. BIRTHPLACE OF FATHER
(State or Country) Mich

12. MAIDEN NAME OF MOTHER: Ruth M Hall

13. BIRTHPLACE OF MOTHER
(State or Country) Princeton Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R A Swenson
(Address) Cambridge Ida

15.
Filed Nov 1 1916
C E Schmutz
Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1916, to Sept 29 1916, that I last saw h.. alive on Sept 29 1916, and that death occured on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:
Interstitial nephritis
(Duration) unknown mos. ds.
Contributory (Secondary) Arteriosclerosis
(Duration unknown mos. ds.
(Signed) Simeon Hopper M. D.
9/30 1916 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise
DATE OF BURIAL 191

20. UNDERTAKER: L L Northern
ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 88
Primary Registration District No. 2164
(No. ..... St.)

File No. 15718
Registered No. .....

1. PLACE OF DEATH.
County of Washington
City of Cambridge
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth L Howton Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Jan (Month) 9 (Day) 1836 (Year)

7. AGE: 80 Yrs. 9 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): North Carolina Tennessee

10. NAME OF FATHER: Wm Rose

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Mahala Cunningham

13. BIRTHPLACE OF MOTHER (State or Country): Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lee Howton
(Address) Cambridge

15. Filed Nov 1 1916 O C Schmuck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6 1916, to Sept 3 1916, that I last saw h er alive on Sept 3 1916, and that death occured on the date stated above, at about 4 P M.

The CAUSE OF DEATH* was as follows:
Mitral Stenosis

(Duration) unknown Yrs. ..... mos. ..... ds.
Contributory (Secondary) age
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Simeon Hopper M. D.
9/9 1916 (Address) Cambridge

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho
DATE OF BURIAL: Sept 7 1916

20. UNDERTAKER: Jos Hudelson
ADDRESS: Cambridge Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & SONS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15719

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Cambridge

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 264

(No. ....., ... St.)

2. FULL NAME Clinton Isaacson

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 7.3 ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Denmark

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nelson Bark

(Address) Cambridge

15. Filed Nov 1 1916

C. E. Schmutz
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: on or about July 5th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h[illegible]alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

[illegible] found dead in his home on July 19th 1916

No Functional Nervous

Whatever (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jas. F. McCann M. D.

7/16 1916 (Address) Weiser Ida County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida — DATE OF BURIAL: July 20 1916

20. UNDERTAKER: J. A. Anderson — ADDRESS: Cambridge

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 88
Primary Registration District No. 2164
File No. 15720
Registered No. .....

1. PLACE OF DEATH.
County of Adams
City of Indian Valley
(No. .... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mabel Henke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Female	White	Single (Write the word.)

6. DATE OF BIRTH.
Sept 21 (Month) (Day) 1916 (Year)

7. AGE
..... Yrs. 22 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... ✓
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Adams County Ida

10. NAME OF FATHER
W E Henke

11. BIRTHPLACE OF FATHER
(State or Country) Montana

12. MAIDEN NAME OF MOTHER
Prudy Linder

13. BIRTHPLACE OF MOTHER
(State or Country) Adams County Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W E Henke
(Address) Cambridge Indian Valley Ida

15.
Filed Nov 1 1916 C E Schmidt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1916, to Oct 18 1916, that I last saw h.. alive on Oct 13 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Tetanus Neonatorum

.....(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Brown M. D.
..... 19..... (Address) Council Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Jno Henkelsan Cambridge — DATE OF BURIAL Oct 15 1916

20. UNDERTAKER Jno Henkelsan — ADDRESS Cambridge Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOBS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2128
File No. 15721
Registered No.

1. PLACE OF DEATH
County of Idaho
City of Kamiah (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sadie Kipp

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	Indian	single

6. DATE OF BIRTH: Aug. (Month) 9th (Day) 1899 (Year)

7. AGE: 17 yrs. 2 mos. 18 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Harrison Kipp

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Daisy Hoyt

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edis Kipp.
(Address) Nezperce, Idaho

15. Filed 11/30 1916 W.T. McMahan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 10 (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1915, to Oct. 28th. 1916, that I last saw her alive on Sept 10th 1916, and that death occurred on the date stated above, at 11:0 P M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 3 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W.T. McMahan M. D.
10/30 1916 (Address) Kamiah, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ed Kipps Ranch, Priv. Cem't — DATE OF BURIAL: 10/30 1916

20. UNDERTAKER: O. J. Johnson — ADDRESS: Kamiah, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Harrison
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)

File No. 15722
Registered No. 92
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amelia Marian

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: April (Month) 6 (Day) 1848 (Year)

7. AGE: 68 yrs. 6 mos. 16 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Robert Higgins

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Mary Holmes

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julia Curtis
(Address) Harrison Ida

15.
Filed Nov 9 1916 R S Jenkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1915, to Oct 21 1916, that I last saw her alive on Oct 20 1916, and that death occurred on the date stated above, at 4 00 P.M.

The CAUSE OF DEATH* was as follows:
nephritis

(Duration) 5 yrs. — mos. — ds.

Contributory (Secondary) uraemia

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) H W Wheeler M. D.
Oct 21 1916 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Harrison Ida
DATE OF BURIAL: Oct 22 1916

20. UNDERTAKER: E W Wheeler
ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 66
Primary Registration District No. 2146
File No. 15723
Registered No. 12

1. PLACE OF DEATH.
County of Latah
City of Bovill
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earnie Junior Smith.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
June (Month) 17 (Day) 1916 (Year)

7. AGE
Yrs. 3 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER: Earnie Smith

11. BIRTHPLACE OF FATHER
(State or Country) Missouri

12. MAIDEN NAME OF MOTHER: Nellie E Wood

13. BIRTHPLACE OF MOTHER
(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs N. E. Smith
(Address) Bovill Ida

15.
Filed 10/14 191 6
J. L. Champion
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22 - 1916, to Oct 12 - 1916, that I last saw ~~him~~ alive on Oct 12 - 1916, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

(Duration) Yrs. mos. 5 ds.
Contributory (Secondary) Broncho Pneumonia
(Duration yrs. mos. 10 ds.

(Signed) F. C. Gibson M. D.
10/14 1916 (Address) Bovill

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 12 days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bovill Ida
DATE OF BURIAL: 10/14 1916

20. UNDERTAKER: J. L. Champion
ADDRESS: Bovill Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15724
Registered No. ____

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. ____, ____ St.)
Registration District No. 39
Primary Registration District No. 3097

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Georgia May Adkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
6. DATE OF BIRTH. Dec (Month) 25 (Day) 1874 (Year)
7. AGE: 41 Yrs. 10 Mos. — ds. IF LESS than 1 day how many ____ hrs. or ____ min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work ____
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
9. BIRTHPLACE (State or Country) Nebraska.
10. NAME OF FATHER Daniel Dolan
11. BIRTHPLACE OF FATHER (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Anna Harris
13. BIRTHPLACE OF MOTHER (State or Country) Kansas
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. Adkins
(Address) ____
15. Filed 10-25 1916 J. V. Mumley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 25 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 19__ to accursed 191__, that I last saw h__ alive on Oct 25 1916 and that death occured on the date stated above, at ____ M.
The CAUSE OF DEATH* was as follows: Pulmonary Hemorrhage
Tuberculosis
Less than 1 hour (Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) Chronic Pulmonary Tuberculosis (Duration ____ yrs. ____ mos. ____ ds.
(Signed) C. A. Bellinger M. D.
10/26 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Pioneer DATE OF BURIAL: 10/26 1916
20. UNDERTAKER: A. E. Emmons ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

HOYNES - YORK CO., PTRS. & BKBS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3 15727
Registered No. 6

1. PLACE OF DEATH.
Registration District No. 31
Primary Registration District No. 2130
County of Canyon
City of Fruitland (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Paul N. Van Der Kar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 3 (Day) 1885 (Year)

7. AGE: 31 yrs. 1 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Theadore Van Der Kar

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Caroline Fish

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ruth D. Van Der Kar
(Address) Payette, Idaho.

15.
Filed Nov. 10 1916 Crispin Wrights
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Oct. (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13th 1916, to Oct 20 1916, that I last saw him alive on Oct 20 1916, and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:
Double Pneumonia

(Duration) ... yrs. ... mos. 7 ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Crispin Wrights M. D.
19... (Address) Fruitland Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Riverside Payette	Oct 23 1916
20. UNDERTAKER	ADDRESS
D. N. Adair Payette	Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 22

Primary Registration District No. 226

File No. 15728

Registered No. 27

1. PLACE OF DEATH.

County of Shoshone

City of Mullan (No. Morning Mine St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Cabrie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1 (Year)

7. AGE

24 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... miner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Germany.

10. NAME OF FATHER Martin Cabrie

11. BIRTHPLACE OF FATHER (State or Country) Germany.

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. Donahue

(Address) Wallace Ida

15. Filed Oct 27 1916 H. C. Murphy Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 23 1916

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:

Fell from Cage into Shaft Causing fracture of skull

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. R. Mowry M. D.

1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence ... Mullan 2da

19. PLACE OF BURIAL OR REMOVAL: Wallace. DATE OF BURIAL: Oct 27 1916

20. UNDERTAKER: Ward Mort Co ADDRESS: Wallace 2da

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15729

Registered No. 24

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 1702

Primary Registration District No. 1800

County of Shoshone

City of Wardner (No. Residence St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stewart Elliot Padfield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: March (Month) 9th (Day) 1867 (Year)

7. AGE: 49 yrs. 7 mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrical engineer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Clair Mich.

10. NAME OF FATHER: Albert L. Padfield

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Mary Ward

13. BIRTHPLACE OF MOTHER (State or Country): Canada, Place Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. S. E. Padfield.
(Address) St Clair Mich

15. Filed Oct 19 1916 H. C. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1916, to Oct 18 1916, that I last saw him alive on Oct 18 1916, and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 2 yrs. 6 mos. — ds.

Contributory (Secondary) Intestinal Peritonitis

(Duration) — yrs. — mos. 2 ds.

(Signed) L. B. Blanchard M. D.

Oct 18 1916 (Address) Burke, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence Helena Montana

19. PLACE OF BURIAL OR REMOVAL: Wallace.

DATE OF ~~BURIAL~~: Oct 20 1916

20. UNDERTAKER: Hasp Mort Co

ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Gem

Registration District No. 2202
Primary Registration District No. 22
(No. Gem St. Idaho)

File No. 15730
Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lawrence Jorgenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: January (Month) 24 (Day) 1916 (Year)

7. AGE: — yrs. 8 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Samuel Jorgenson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Olive Lawrence

13. BIRTHPLACE OF MOTHER (State or Country): Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Olive Jorgenson
(Address) N Gem

15. Filed Oct 17 1916 W. H. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 10 (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/10/16 191.., to 10/11/16 191.., that I last saw him alive on 10/11/16 191.., and that death occurred on the date stated above, at 4:50 A.M.

The CAUSE OF DEATH* was as follows:

Intra Pneumonia

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) Influenza

(Duration) ... yrs. 10 mos. ... ds.

(Signed) Edward C. Fraun M. D.

10/13/16 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho
DATE OF BURIAL: Oct 13 1916

20. UNDERTAKER: Bruce D. Worstell
ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg Ida
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 122
Primary Registration District No. 3200
(No. Gem Idaho St.)

File No. 15731
Registered No. 24
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alex Smith Ahola

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: December 22 (Month) (Day) 1 (Year)

7. AGE: 39 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: E Ahola

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Alex Smith Ahola
(Address) Gem Idaho

15. Filed Oct 17 1916 W. E. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 11 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pulmonary Phthisis

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Mary Smyth M. D.
19.... (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho | DATE OF BURIAL: Oct 13 1916
20. UNDERTAKER: B. Barrett | ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 15733
Registered No. 57

1. PLACE OF DEATH.
County of Madison
City of Rexburg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John L. Farnes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal.
4. COLOR OR RACE: White
5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.)

6. DATE OF BIRTH. Dec. (Month) 17 (Day) 1858 (Year)

7. AGE: 57 Yrs. 9 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER John W. B. Farnes

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Anna Isaak

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. J. L. Farnes
(Address) Rexburg

15. Filed 10/23 1916 G. L. Teeple Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1916, to Sept 9 1916, that I last saw him alive on Sept 9 1916, and that death occured on the date stated above, at 8a M.

The CAUSE OF DEATH* was as follows:
Fracture of Base of Skull, Result of Fall
(Duration) ..... Yrs, ... mos. 3 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Holmes & Maeser M. D.
19..... (Address) By J. Maeser.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 9/11 1916

20. UNDERTAKER: Rexburg — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 15735
Registered No. 52

1. PLACE OF DEATH
County of Madison
City of Rexburg
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Temperance Tennyson R. Hinckley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Jan (Month) 4 (Day) 1836 (Year)

7. AGE: 80 Yrs. 9 Mos. 10 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: House
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Joel Ricks

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Eleanor Marion

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ella Hinckley Hoopes
(Address) Logan Utah

15. Filed 10/8 191 6

G G Espe
Local Registrar

BYNS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
10 (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-7 1916, to 10-1 1916,
that I last saw h[illegible] alive on 10-1 1916,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senile

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G G Espe M. D.

19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 10/8 1916

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ..... , ... St.)

File No. 15736
Registered No. 5-4

1. PLACE OF DEATH.
County of Madison
City of Lyman
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Percy Clinton Atkinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	

6. DATE OF BIRTH. April (Month) 21 (Day) 1916 (Year)

7. AGE ..... Yrs. 5 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Lyman

10. NAME OF FATHER William E. Atkinson

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Marintha A. Morris

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. Atkinson
(Address) Lyman

15. Filed 10/8 1916 G. G. Teske Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
10 (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-15 1916, to 10-8 1916, that I last saw h... alive on 10-18 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Enteritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) G. G. Teske M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Archer	10/9 1916
20. UNDERTAKER J. Ryorng	ADDRESS Ryburg

of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & ENGS. 24063

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No.
Registered No. 15237

1. PLACE OF DEATH.
County of Madison
City of Rexburg (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Timothy S Parkinson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 1 (Day) 1876 (Year)

7. AGE: 39 Yrs. 11 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Timothy Parkinson

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Jane Greer

13. BIRTHPLACE OF MOTHER (State or Country): America.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jane Greer
(Address) Hillsville Utah

15. Filed 10-9 1916

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19 1916, to Oct 9 1916, that I last saw h[illegible] alive on Oct 9 1916, and that death occured on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:
Bacillary Dysentery
(Duration) 2 Yrs. mos. 15 ds.
Contributory (Secondary) Lobar Pneumonia
(Duration ..... yrs. ..... mos. 7 ds.
(Signed) J. Rae [illegible] M. D.
1916 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar City — DATE OF BURIAL: 10/12 1916

20. UNDERTAKER: John S Phillips. — ADDRESS: Rexburg

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. .... St.)

File No. 15738
Registered No. 3-6

1. PLACE OF DEATH.
County of Madison
City of Burton
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert B. Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.)

6. DATE OF BIRTH. Aug (Month) 30 (Day) 1840 (Year)

7. AGE: 76 Yrs. 1 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Daniel Hill

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Elizabeth Brice

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Daniel S. Hill
(Address) R F D - # 1

15. Filed 10/16- 1916
G. Foster
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h...alive on ..... 191...,
and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Found dead in bed -
Verdict Died from
Natural Causes
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. Raymond Coroner
19.... (Address) Ryburg -

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton
DATE OF BURIAL: 10/17 1916

20. UNDERTAKER: J Rayburg
ADDRESS: Ryburg

STUB - YORK CO., PTRS. & SONS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15739

Registered No. 57

1. PLACE OF DEATH.

County of Fremont

City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 2177

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Juniata Morris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Sept (Day) 17 1914

7. AGE: 2 Yrs. 5 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rexburg

10. NAME OF FATHER: Elias Morris

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Tyler

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elias Morris

(Address) .....

15. Filed 10/15 1916

Y E Espe
Local Registrar

SVMS - YORK CO., PTRS. & SONS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) Oct (Day) 16 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1916, to Oct 16 1916, that I last saw h alive on Oct 16 1916, and that death occured on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

Acute Enteritis

..... (Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) A Morrfield M. D.

10/16 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg Idaho — DATE OF BURIAL: 10/18 1916

20. UNDERTAKER (Address) Phillips — ADDRESS Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 15740
Registered No. 58

1. PLACE OF DEATH.
County of Ada
City of Independence (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ira D. Spaulding

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH. May (Month) 19 (Day) 1849 (Year)
7. AGE: 67 Yrs. 4 Mos. 29 Ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Utah
10. NAME OF FATHER: Ira N. Spaulding
11. BIRTHPLACE OF FATHER (State or Country): America
12. MAIDEN NAME OF MOTHER: Eliza Drake
13. BIRTHPLACE OF MOTHER (State or Country): America
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dave Spaulding
(Address) Independence
15. Filed 10/18 1916 G.G. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 17 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 10-16 1916, to 10-17 1916, that I last saw h~~im~~ alive on 10-16 1916, and that death occured on the date stated above, at 4 M.
The CAUSE OF DEATH* was as follows:
Obstruction of the bowel
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) G.G. Espe M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL: 10/20 1916
20. UNDERTAKER: John Phillips — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

DYER - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

STATE BOARD OF H... Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Madison

City of Rexburg

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

File No. 15741

Registered No. 5-9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leada Le Rue Aldridge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 21 (Day) 1901 (Year)

7. AGE: 15 Yrs. 4 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Isaac Aldridge

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Jane Woodard

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alta Aldridge

(Address) Rexburg

15.

Filed 10/23 1916

Local Registrar

BYUH - YORK CO./PTRS. & SPRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-21 1916, to 10-21 1916, that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BERIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 10/24 1916

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15712
Registered No. 68

1. PLACE OF DEATH.

Registration District No. 100
Primary Registration District No. 2178
County of Madison
City of Rexburg (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Juliana Petersen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Feb. (Month) 25 (Day) 1837 (Year)

7. AGE: 79 Yrs. 8 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Weaver
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Hans Jensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Christina Fast
(Address) Rexburg

15. Filed OCT 24 1916 191.....
G G Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
10 (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Myocardial disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G G Espe M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: John Phillips — DATE OF BURIAL: Oct 26 191 6

20. UNDERTAKER: Burton — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

AYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 107
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 15743
Registered No. 61

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Madison
City of Rylburg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dr. O. C. Crosby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 24 (Day) 1843 (Year)

7. AGE: 73 Yrs. 3 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: John Crosby

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm. E. Crosby
(Address) Rylburg

15. Filed 10/27 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 25 1916, to Oct. 26 1916, that I last saw h[illegible] alive on Oct. 26 1916 and that death occured on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy, Cerebral
(Duration) ..... Yrs. ..... mos. 1/2 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
19..... (Address) Rylburg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Logan Utah
DATE OF BURIAL: 10/28 1916

20. UNDERTAKER: Wyoming
ADDRESS: Rylburg

SYMS - YORK CO., PTRS. & BORS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 15744
Registered No. 62

1. PLACE OF DEATH.
County of Madison
City of Rexburg (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josiah Ricks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. May (Month) 27 (Day) 1845 (Year)

7. AGE: 71 Yrs. 5 Mos. 8 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Joel Ricks

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Elenor Martin

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nathan Ricks
(Address) Rexburg

15. Filed 11-6 1916
G. G. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-20 1916, to 11-4 1916, that I last saw him alive on 11-4 1916, and that death occured on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:
Enlarged prostate

(Duration) ..... Yrs. ..... mos. ..... da.
Contributory (Secondary)
(Duration ..... Yrs. ..... mos. ..... da.
(Signed) G. G. Espe M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: John Phillips — DATE OF BURIAL: 11/8 1916
20. UNDERTAKER: Rexburg — ADDRESS: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STAR - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 15745
Registered No. 63

1. PLACE OF DEATH.
County of Minidoka
City of Rex

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter Paul

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH. March 10 (Month) (Day) 1834 (Year)
7. AGE: 72 Yrs. 9 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Gradesman
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): England
10. NAME OF FATHER: Wm Paul.
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Elizabeth Gain
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs John Whitney
(Address) Rex
15. Filed 11/10 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 9 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 11/1 1916, to 11/9 1916, that I last saw him alive on 11/9 1916, and that death occured on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Acute Bronchitis
(Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rex. DATE OF BURIAL: 11/11 1916
20. UNDERTAKER: John Phillips ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147
Primary Registration District No. 67
File No. 15747
Registered No. 33

1. PLACE OF DEATH.
County of Latah
City of Helmer
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert C. Entsler

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	single

6. DATE OF BIRTH: Oct. (Month) 3 (Day) 1903 (Year)

7. AGE: 11 yrs. 0 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Adam Entsler

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Mary Robert

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed ..... 191...
R. C. Faust
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1916, to Oct. 15 1916, that I last saw him alive on Oct. 15 1916, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
whooping cough

(Duration) 0 yrs. 3 mos. — ds.
Contributory (Secondary) dropsy
(Duration) 0 yrs. 1 mos. 15 ds.

(Signed) R. C. Faust M. D.
10/17 1916 (Address) Deary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow Cemetery	10/18 1916
20. UNDERTAKER	ADDRESS
J. E. Pickard	Troy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15748
Registered No. 36

1. PLACE OF DEATH.
County of Latah
City of Kendrick (No. ....., R.F.D. ....., St.)
Registration District .....
Primary Registration .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Helmer K. Slind

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH: Sept (Month) 16 (Day) 1916 (Year)
7. AGE: — yrs. — mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Geo K Slind
11. BIRTHPLACE OF FATHER (State or Country): Minnesotta
12. MAIDEN NAME OF MOTHER: Hope R Beckley
13. BIRTHPLACE OF MOTHER (State or Country): Ohio
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo K. Slind
(Address) Kendrick Ida.
15.
Filed Oct 6 1916 J. E. Hoyt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

DEATH Oct 5 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29th 1916 to Oct 5th 1916 that I last saw h[illegible] alive on Oct 3rd 1916 and that death occurred on the date stated above, at 3. P M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... yrs. ..... mos. 18 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. G. Rothwell M. D.

Oct 6 1916 (Address) Kendrick Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Vista Rose Cemetery — DATE OF BURIAL: Oct 7 1916
20. UNDERTAKER: E. E. Beckham — ADDRESS: Kendrick Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15719
Registered No. 34 35

1. PLACE OF DEATH.
County of Latah
City of Kendrick

Registration District No. 63
Primary Registration District No. 2143
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gustave Hammaford Hammarell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: May (Month) 27 (Day) 1837 (Year)

7. AGE: 79 yrs. 4 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: retired farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Robert Hammarell

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Lady Agnes Hammond

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E H Hammarell
(Address) Kendrick Ida.

15.
Filed Oct 26 1916
J E Hoyt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1913, to Oct 26 1916 that I last saw h[illegible] alive on Oct 24 1916 and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 6 yrs. — mos. — ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Rathwell M. D.
Oct 26 1916 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Cloverland Wash
DATE OF BURIAL: Oct 28 1916

20. UNDERTAKER: E. E. Bechtol
ADDRESS: Kendrick Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1575
Registered No. 34

1. PLACE OF DEATH.
County of Latah
City of Kendrick R.F.D. 2
Registration District No. 63
Primary Registration District No. 7143
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Valborg Oveson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Sept 27. (Month) (Day) 1823 (Year)

7. AGE: 93 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Karsten Garstad

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Martha Mickelsen

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Slind
(Address) Kendrick Ida

15.
Filed Oct 20 1916
J E Hoyt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sep (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191....
that I last saw h..... alive on ..... 191....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Old age. Found dead in her bed in morning. Had not been sick. No doctor
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Slind M. D.
10-20 1916 (Address) Kendrick

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lutheran Cemetary
DATE OF BURIAL: Sept 26 1916

20. UNDERTAKER: E E Bechtol
ADDRESS: Kendrick Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15751

Registered No. 18

1. PLACE OF DEATH.

County of Cassia

City of Oakley

Registration District No. 120

Primary Registration District No. 2199

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Thurston McMurray

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Boy Single

6. DATE OF BIRTH. Dec (Month) 8 (Day) 1902 (Year)

7. AGE: 13 Yrs. 10 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cassia Co

10. NAME OF FATHER: Wilford C McMurray

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Rosilate Snedaker

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. C. McMurray

(Address) Oakley Idaho

15.

Filed 11-2 1916 Florence Dahle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1916, to Oct 27 1916, that I last saw him alive on Oct 27 1916, and that death occured on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:

Choaked - Closing of Larynx
Cause not determined
Throat culture negative.

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Langsupatter M. D.

Oct 27 1916 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley — DATE OF BURIAL: 10-28 1916

20. UNDERTAKER: H. D. Haight — ADDRESS: Oakley.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 15754
Registered No. 80

1. PLACE OF DEATH.
County of Canyon
City of Caldwell Rural
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME G. M. Wilson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Dec. (Month) 1 (Day) 1851 (Year)

7. AGE
65 Yrs. 11 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Ohio.

10. NAME OF FATHER: J. A. Wilson

11. BIRTHPLACE OF FATHER
(State or Country) Penn.

12. MAIDEN NAME OF MOTHER: Isabel Cam.

13. BIRTHPLACE OF MOTHER
(State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs G. M. Wilson
(Address) Caldwell - Idaho.

15.
Filed 11-6-1916 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1916, to Nov. 5 1916, that I last saw him alive on Oct. 30 1916 and that death occured on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 5 yrs 6 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs ..... mos. ..... ds.
(Signed) C. M. Foley M. D.
Nov 6 1916 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Brookfield Mo
DATE OF BURIAL: 11/6 1916

20. UNDERTAKER: Burgen Funeral Co
ADDRESS: Caldwell.

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 15755
Registered No. 79

1. PLACE OF DEATH.
County of Canyon
City of Caldwell Rural (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James David Johnston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 23 (Day) 1828 (Year)

7. AGE: 88 Yrs. 3 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) North Carlina

10. NAME OF FATHER James D. Johnston

11. BIRTHPLACE OF FATHER (State or Country) N. C.

12. MAIDEN NAME OF MOTHER Frankie Satterfield

13. BIRTHPLACE OF MOTHER (State or Country) N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) T. T. Johnston
(Address) Caldwell Idaho

15. Filed 11-4-1916 John T. Meyer Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1916, to 11/3/16 1916, that I last saw h in alive on 11/3/16 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Senility
.....
.....
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteriosclerosis
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Cue M. D.
11/4 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 11-4-1916

20. UNDERTAKER: Binford Furniture Co
ADDRESS: Caldwell Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 3

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. 2005
File No. 15756
Registered No. 78

1. PLACE OF DEATH.
County of Canyon
City of Caldwell Rural
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ann Billups

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. August 31 1830
(Month) (Day) (Year)

7. AGE: 86 Yrs. 2 Mos. 1 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Household work—on Farm
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Hardon Co. Ky.

10. NAME OF FATHER: David Smith

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Mary Gray

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. E. Billups
(Address) Caldwell, Idaho

15.
Filed Nov. 3 - 1916
John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1916, to Nov 2 191_, that I last saw her alive on Oct 13 191_, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Influenza
Pneumonia
(Duration) Several Yrs. 1 mos. ____ ds.

Contributory (Secondary)
(Duration ____ yrs. ____ mos. ____ ds.

(Signed) [illegible] M. D.
11/2 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 11/3 1916

20. UNDERTAKER: Buckford Furniture Co Caldwell
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ....., ... St.)

File No. 15757
Registered No. 77

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza J. Sorenson.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. Nov (Month) 2 (Day) 1838 (Year)

7. AGE: 77 Yrs. 11 Mos. 29 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Mr. Bitts.

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary E. Crook
(Address) Dallas Oregon

15. Filed Nov. 2nd 1916 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1916, to Oct 31 1916, that I last saw h[er] alive on Oct 31 1916, and that death occured on the date stated above, at 2-00 M.

The CAUSE OF DEATH* was as follows:
Pneumonia.

(Duration) ✓ Yrs. ✓ mos. ✓ ds.

Contributory (Secondary) Senility.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. B. Smith, M. D.
11/1/1916 (Address) Nampa, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Evans Colorado — DATE OF BURIAL ..... 191...

20. UNDERTAKER: Beckham Case Co — ADDRESS: Caldwell

BYRD - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 15758
Registered No. 76

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. May (Month) 11 (Day) 1850 (Year)

7. AGE: 66 Yrs. 5 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John Ramsey

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Francis Tomlinson

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Fannie Ford
(Address) Caldwell Idaho

15. Filed 10-31- 1916 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 27th 1916., to Oct. 30th 1916., that I last saw her alive on Oct. 30th 1916., and that death occured on the date stated above, at 4-35 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Chronic Rheumatism

(Duration) 6 yrs. ..... mos. ..... ds.

(Signed) J. M. Henry M. D.
10/31/1916. (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Nov. 1 1916

20. UNDERTAKER: Pelton Casebeer Co — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2004
File No. 15759
Registered No. 75

1. PLACE OF DEATH.
County of Canyon
City of Parma R.D. 1
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rebecca Hershey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Mch (Month) 15 (Day) 1831 (Year)

7. AGE: 85 Yrs. 7 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maryland

10. NAME OF FATHER: Don't know

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. D. Lanyon
(Address) Parma Idaho R.D. 1

15. Filed 10-31-1916 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1916, to Oct. 30- 1916, that I last saw h.. alive on ..... 15 1916, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Senility - and
Myocarditis.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteriosclerosis.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. L. Newell M. D.
10/31/1916 (Address) Wilder Idaho.
Co'r J. D. Lanyon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wilder Cemetery — DATE OF BURIAL: 10 31 1916

20. UNDERTAKER: Binford Furniture Co. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 15760
Registered No. 74

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Martin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 9 (Day) 1863 (Year)

7. AGE: 53 Yrs. 1 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. House Keeper.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Angus Martin

11. BIRTHPLACE OF FATHER (State or Country) Scotland.

12. MAIDEN NAME OF MOTHER Sarah McKinley

13. BIRTHPLACE OF MOTHER (State or Country) Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Margaret Martin
(Address) Caldwell Ida.

15. Filed Oct. 30 1916 — John D. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1916, to Oct. 29 1916, that I last saw her alive on Oct 25 1916, and that death occured on the date stated above, at 4-30 P.M.

The CAUSE OF DEATH* was as follows:
Intestinal Tuberculosis

(Duration) 2 or 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Cachexia
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. M. Talley M. D.
Oct 30 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: Oct 30 1916

20. UNDERTAKER: Beckham Case Co. ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15761

Registered No. 73

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

(No. ....., ... St.)

Registration District No. 3

Primary Registration District No. 1005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clare Barber

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June 25 1916
(Month) (Day) (Year)

7. AGE: Yrs. 4 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Caldwell

10. NAME OF FATHER Herman Barber

11. BIRTHPLACE OF FATHER (State or Country) Avondale R. D.

12. MAIDEN NAME OF MOTHER Mellana Wiseman

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Herman Barber
(Address) Caldwell Idaho

15.
Filed Oct. 29 1916
John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 28 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1916, to Oct 28 1916, that I last saw him alive on Oct 28 1916 and that death occured on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:
Tranitoir & Mesenteric

(Duration) Yrs. 2 mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Miller M. D.
10-29-1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	10-29-1916

20. UNDERTAKER	ADDRESS
Bickford Furniture Co	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. ..... St.)

File No. 15762
Registered No. 72

1. PLACE OF DEATH.
County of Canyon
City of Caldwell.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Franklin Lobb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 28 (Day) 1902 (Year)

7. AGE: 14 Yrs. 4 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Oklahoma

10. NAME OF FATHER W. F. Lobb.

11. BIRTHPLACE OF FATHER (State or Country) Illinois.

12. MAIDEN NAME OF MOTHER Jennie B. Walker

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. F. Lobb
(Address) Caldwell R.D. #1

15. Filed 10-27-1916 John D. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 18 1916, to Oct 26 1916, that I last saw h[im] alive on Oct 25 1916, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
T[yphoid] Fever -
.....(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary)
.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Stowers M. D.
10/27/1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: Oct 27 1916
20. UNDERTAKER: Beckham Case Co. ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 15763
Registered No. 71

1. PLACE OF DEATH.

County of Canyon
City of Caldwell
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James H Lybolt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. April (Month) 16 (Day) 1846 (Year)

7. AGE 70 Yrs. 6 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Jacob Lybolt

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Owen L Stevens
(Address) Route 2 Caldwell Ida

15.
Filed Oct 26 1916 John L Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Internal Hemorhage
Caused from a fall

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A A Faris-Coroner
19.... (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	10/26 1916
20. UNDERTAKER Bunford Funeral Co	ADDRESS Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2005
File No. 15765
Registered No. 69

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis Francis West

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Aug (Month) 12 (Day) 1916 (Year)

7. AGE: Yrs. 2 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. —
(b) General nature of industry, business, or establishment in which employed (or employer). —

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER William L. West

11. BIRTHPLACE OF FATHER (State or Country) Indianna.

12. MAIDEN NAME OF MOTHER Francis F. Lint

13. BIRTHPLACE OF MOTHER (State or Country) California.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. W. West
(Address) Ontario, Oregon

15. Filed 10-20- 1916 John S. Meyers Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1916, to Oct 19 1916, that I last saw h[illegible] alive on Oct 19 1916, and that death occured on the date stated above, at 11-18 A.M.

The CAUSE OF DEATH* was as follows:

Inanition &
Marasmus

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) S. J. Mullin M. D.
Oct 20 1916. (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	Oct 20 1916
20. UNDERTAKER	ADDRESS
Pickham Care Co	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15766
Registered No. 35

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1009
(No. White Hospital St.)

2. FULL NAME Low Sleuker

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 25 (Day) 1916 (Year)

7. AGE: [illegible] yrs. mos. ds.
IF LESS than 1 day how many ... hrs. or ... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston Idaho

10. NAME OF FATHER: Low Sleuker

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Stella McCuttie

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs S.A. Spengler
(Address) Lewiston Idaho

15. Filed Nov 10 1916 L.J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 191[illegible], to Oct 25 191[illegible]
that I last saw h... alive on ... 191...
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Traumatic injury of respiratory Centre during delivery.

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) E L Wurtz M. D.
Nov 8 1916 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds.
In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: ... 191...

20. UNDERTAKER: [illegible]
ADDRESS: [illegible] Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15767
Registered No. 21

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Alice H Pickering

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Sept (Month) 25 (Day) 1853 (Year)
7. AGE: 62 yrs. 8 mos. 19 ds. IF LESS than 1 day how many.....hrs. or .....min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ind.
10. NAME OF FATHER: Alvin H Binford
11. BIRTHPLACE OF FATHER (State or Country): Va.
12. MAIDEN NAME OF MOTHER: Tamer Hawkins
13. BIRTHPLACE OF MOTHER (State or Country): Ida.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): L V Pickering
(Address):
15.
Filed Nov. 10 1916 L G Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 24th (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1916, to Sept 24 1916
that I last saw h[er] alive on Sept 23 1916
and that death occurred on the date stated above, at 3-40 M.
The CAUSE OF DEATH* was as follows:

Uraemic Coma
..... (Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) Chronic Interstitial Nephritis
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O C Carrow M. D.
..... 19..... (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds.
In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho
DATE OF BURIAL: Sept 26-1916
20. UNDERTAKER: Kassar
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96 = 19[illegible]

Primary Registration District No. 1009

File No. 15768

County of Nez Perce

City of Lewiston (No. ....., ... St.)

Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Oscar W. Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower

6. DATE OF BIRTH: Not known (Month) ..... 1 (Day) ..... (Year)

7. AGE: 61 yrs. (?) mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. J. Perkins
(Address) Lewiston Idaho

15.
Filed Nov. 10 - 191[illegible] L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1916, to Sept 26 1916, that I last saw h[illegible] alive on Sept 26 1916 and that death occurred on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:

Appendicitis & obstruction of bowels

(Duration) 6 yrs. 6 mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Perkins M. D.

9/30 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 6 mos. 1 days. In the State not known yrs. mos. days.

Where was disease contracted if not at place of death? Lewiston's Orchards

Former or usual residence. Coeur d'Alene Wash.

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: Oct 3 1916

20. UNDERTAKER: [illegible] — ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15769
Registered No. 24

1. PLACE OF DEATH.
County of Ada
City of Boise
Registration District No. 96
Primary Registration District No. 1009
(No. White's Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Amanda Hampton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 3 (Day) 188 (Year)

7. AGE: 28 yrs. 5 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. D.

10. NAME OF FATHER: Martin Gottenberg

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Amelia Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Gottenberg
(Address) Nampa

15.
Filed Nov 10 1916 L. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1916, to Oct 6 1916
that I last saw h[er] alive on Oct 6 1916
and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
General Suppurative Peritonitis.
& Toxaemia.

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary): Unknown.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. K. White M. D.
Oct 6 1916 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Julietta
DATE OF BURIAL ..... 191...

20. UNDERTAKER: D Worsar
ADDRESS: 10/6/16

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15770

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston

Registration District No. 2
Primary Registration District No. 1209
(No. 1717 Prospective St.)

2. FULL NAME Nettie C Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 27 (Day) 1854 (Year)

7. AGE: 62 yrs. 0 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: C B. Cosper

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Mary Jane Wilson

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J F Williams
(Address) Lewiston

15.
Filed Nov. 10 1916 L G Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 13 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1916, to Oct 13 1916
that I last saw h[illegible] alive on Oct 12 1916
and that death occurred on the date stated above, at 1 A.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Phthisis

(Duration) 3 yrs. mos. ds.
Contributory (Secondary): Exhaustion
(Duration) 1 yrs. mos. ds.

(Signed) H W Shaw M. D.
Oct 13 1916 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 10/14 1916

20. UNDERTAKER: Larson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15771
Registered No. 27

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
Registration District No. 9
Primary Registration District No. 1609
(No. St. Joseph Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME J. C. Fargo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: March (Month) 22 (Day) 1841 (Year)

7. AGE: 76 yrs. 6 mos. 22 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Hiram Fargo

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Electa Clark

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. M. Fargo
(Address) Lewiston Ida

15.
Filed Nov. 10 1916 L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 14. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 10th 1916, to Oct 14 1916
that I last saw him alive on Oct 14 1916
and that death occurred on the date stated above, at 6-35 P M.

The CAUSE OF DEATH* was as follows:
Senile gangrene

(Duration) x yrs. 2 mos. 4 ds.
Contributory (Secondary) Arterio-sclerosis.
(Duration) 1 yrs. mos. ds.

(Signed) L. J. Perkins M. D.
10/15 1916 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: 10/16 1916

20. UNDERTAKER: Hasson
ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15772
Registered No. 98

1. PLACE OF DEATH. Registration District No. 96
County of Nez Perce Primary Registration District No. 1009
City of Lewiston (No. 0116, 8th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Dr Frank Sterling

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH: Oct. (Month) 16 (Day) 1831 (Year)
7. AGE: 85 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Physician
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): England
10. NAME OF FATHER: — Sterling
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Sterling
(Address) Lewiston Ida
15.
Filed Nov. 10 1916 L. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 10 (Month) 15 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...
that I last saw him alive on 10/15/ 1916
and that death occurred on the date stated above, at 11.30 A.M.
The CAUSE OF DEATH* was as follows:
Old Age
(Duration) ..... yrs. about 6 mos. ..... ds.
Contributory (Secondary) Senility
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F. M. Hamm M. D.
10/16/ 1916 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 10/16 1916
20. UNDERTAKER: L. Larson — ADDRESS: Lew

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15773

Registered No. 30

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ingabo Stockslager Thiessen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 19 (Day) 1883 (Year)

7. AGE: 33 Yrs. 11 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... At Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER C. O. Stockslager

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Ingabo Christman

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. D. C. Thiessen

(Address) Lewiston Ida

15.

Filed Nov. 10 - 1916

L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13th 1916, to Oct 17th 1916, that I last saw her alive on Oct 17th 1916, and that death occured on the date stated above, at 4:00 M.

The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Uterine Embolus

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. C. Graden M. D.

19..... (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 10/19 1916

20. UNDERTAKER: H. K. Merchant — ADDRESS: Clarkston Wash

BYRNS - YORK CO., PTRS. & BKBS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15774

Registered No. 8

1. PLACE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

County of .....

City of ..... (No. St. Joseph Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Rensellear W Rhenbottom

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: July (Month) 1 (Day) 1848 (Year)

7. AGE: 68 yrs. 3 mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Printer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: R W Rhenbottom

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mary Olney

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Alice Johnson
(Address) Clarkston Wash

15.
Filed Nov. 10 1916 L J. Parkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 1916, to Oct 17 1916, that I last saw him alive on Oct 17 1916, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Interstitial nephritis

..... (Duration) Do not know yrs. ..... mos. ..... ds.
Contributory (Secondary) Operation for Strangulated Hernia Sept 27.
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) David H Vaughn M. D.
Oct 17 1916 (Address) Clarkston Wn

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: C. J. Vassar — DATE OF BURIAL: Oct 18 1916

20. UNDERTAKER: C J Vassar — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15775

Registered No. 32

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

Registration District No. 9

Primary Registration District No. 1009

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Robert Sampson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 28 (Day) 1915 (Year)

7. AGE: 1 Yrs. 9 Mos. XX ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER L E Sampson

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Lottie Nickler

13. BIRTHPLACE OF MOTHER (State or Country) Missouri.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E J Sampson

(Address) Lewiston Idaho.

15.

Filed Nov. 10 1916

L J Parkin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-15 1916, to Oct-19 1916, that I last saw him alive on Oct-19 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis

(Duration) Yrs. about mos. 10 ds.

Contributory (Secondary) not known

(Duration yrs. mos. ds.

(Signed) Drs Alley & Bradbrook M. D.

Oct 20 1916 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 10/20 1916

20. UNDERTAKER: H P Merchant — ADDRESS: Clarkston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15776

Registered No. 32

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston Ida

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Abbott

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 1 (Day) 1838 (Year)

7. AGE: 78 Yrs. 9 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ills

10. NAME OF FATHER: Isaiah Abbott

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Middleton

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Abbott

(Address) Lewiston Idaho

15.

Filed Nov. 10 1916

L J Perkins
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1915, to 10-19- 1916, that I last saw h[illegible] alive on 10/19 1916, and that death occured on the date stated above, at 7.30 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterio sclerosis

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) J. P. Harris, M. D.

10/19 1916 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 6 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? —

Former or usual residence Lewiston Ida.

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: 10/20 1916

20. UNDERTAKER: H P Merchant — ADDRESS: Clarkston

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15777
Registered No. 34

1. PLACE OF DEATH. Registration District No. 96
County of ..... Primary Registration District No. 1009
City of ..... (No. Gooch Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. L. Dyer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Not definite (Month) / (Day) 1 (Year)

7. AGE: 82 yrs. More ~~mos.~~ less ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Dyer
(Address) Grangeville Idaho

15. Filed Nov. 10 1916 L. G. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1916, to Oct 21 1916 that I last saw h~~im~~ alive on Oct 20 1916 and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Fracture of Femur

..... (Duration) ..... yrs. 7 mos. 11 ds.
Contributory (Secondary) Diabetis Mellitus
..... (Duration) ..... yrs. 4 mos. ..... ds.

(Signed) Elwood S Braddock M. D.
Oct 21 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 10/22/1916

20. UNDERTAKER: Larson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15778
Registered No. 36

1. PLACE OF DEATH. Registration District No. 96
County of Nez Perce Primary Registration District No. 0009
City of Lewiston (No. 412 15th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John Kidd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	married

6. DATE OF BIRTH Sept (Month) 12 (Day) 1868 (Year)

7. AGE 48 yrs. 1 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... retired
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland,

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (State or Country) Ireland,

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nannie Kidd
(Address) Lewiston

15.
Filed Nov. 10 1916 L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw him alive on Oct 25 1916
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. J. Perkins M. D.
Oct 26 1916 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL City — DATE OF BURIAL Oct 26 1916

20. UNDERTAKER J. Lassar — ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15779
Registered No. 23

1. PLACE OF DEATH.
County of
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9
Primary Registration District No. 1
(No. 127 Lake river Ave St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mary Anfbin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 9 (Month) 28 (Day) 1916 (Year)

7. AGE: — yrs. — mos. — ds.
IF LESS than 1 day how many 12 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Baby
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston Ida.

10. NAME OF FATHER: Joe Anfbin

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Gertrude Smith

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. H. Harris
(Address) Lewiston Ida.

15.
Filed Nov. 10- 1916 L. G. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/28/ 1916, to 9/28/ 1916 that I last saw h[illegible] alive on 9/28/ 1916, and that death occurred on the date stated above, at 1 a. M.

The CAUSE OF DEATH* was as follows:
Insufficient vitality due to premature birth

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary): Premature birth
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. H. Harris M. D.
9/29/ 1916 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: 9/30 1916

20. UNDERTAKER: J. Vassar
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18172

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15780
Registered No. 26

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston

Registration District No. 9c
Primary Registration District No. 1009
(No. 907, 14th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Fredrick Alburn Edick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 27 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds. 17
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston Idaho

10. NAME OF FATHER: Alburn J Edick

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Alma Isserstedt

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): A J Edick
(Address): 907 14th St Lewiston

15.
Filed Nov. 10 - 1916
P. J. Vassar
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 1916, to Oct 14 1916
that I last saw him alive on Oct 14 1916
and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Patent foramen Ovale

..... (Duration) ..... yrs. ..... mos. 18 ds.
Contributory (Secondary): Premature Birth
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Oliver G Broadbeck M. D.
Oct 14 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: Oct 14 1916

20. UNDERTAKER: C J Vassar
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15781

Registered No. 29

Registration District No. 96

Primary Registration District No. 1105

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston Ida.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Benson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. October (Month) 15 (Day) 1916 (Year)

7. AGE ..—.. Yrs. ..—.. Mos. ..1.. ds.

IF LESS than 1 day how many 5½ hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Lewiston. Idaho

10. NAME OF FATHER Clarence McGuire

11. BIRTHPLACE OF FATHER (State or Country) xx X

12. MAIDEN NAME OF MOTHER Alta Benson

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs H M Benson

(Address) Clarkston Wash.

15. Filed Nov. 10 1916 — L. Perkins, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5 a m 10-11- 1916, to 10:30 a m 10-16- 1916, that I last saw her alive on ..... 191..., and that death occured on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Patulous Foramen Ovale in Inter auricular septum

(Duration) ..... Yrs. ..... mos. 5½ hrs. ds.

Contributory (Secondary) Prematurity.

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr. E. L. White M. D.

10-17-1916 (Address) 1504 Main St.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? Intrauterine

Former or usual residence Clarkston, Wash

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash — DATE OF BURIAL: Oct-17-1916

20. UNDERTAKER: H R Merchant — ADDRESS: Clark st.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Harrison

Registration District No. 12

Primary Registration District No. 2204

(No. ..... St.)

File No. 15782

Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (X) Aug (Month) 6 (Day) 1916 (Year)

7. AGE: ..... Yrs. ..... Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Harrison

10. NAME OF FATHER Chas Johnson.

11. BIRTHPLACE OF FATHER (State or Country) Port Allegany Pa

12. MAIDEN NAME OF MOTHER Elizabeth Larkin

13. BIRTHPLACE OF MOTHER (State or Country) Cleveland Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas G. Johnson

(Address) Harrison Idaho

15. Filed Nov 9 1916 R S Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6 1916, to Aug 31 1916, that I last saw h e l alive on Aug 25 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W H Kennedy M. D.

9-1 1916 (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Harrison

DATE OF BURIAL Sept 2 1916

20. UNDERTAKER E. W. Wheeler

ADDRESS Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & STNRS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 126

Primary Registration District No. 2204

File No. 15783

County of Kootenai

City of Harrison Ida (No. ....., ... St.)

Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles De Andrea

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH: Oct (Month) 30 (Day) 1868 (Year)

7. AGE: 48 yrs. 10 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Dominick De Andrea

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Angeline Mary —

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank De Andrea
(Address) Harrison Idaho

15. Filed Nov 9 1916 R.S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from sept 5 1916., to Sept 6 1916, that I last saw him alive on Sept 6 1916, and that death occurred on the date stated above, at 1.30 P M.

The CAUSE OF DEATH* was as follows:
Accidental Fracture of Skull

(Duration) — yrs. — mos. one ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) F W Didier M. D.

Sept 6 1916 (Address) Harrison Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Harrison Ida — DATE OF BURIAL: Sept 7 1916

20. UNDERTAKER: E. W. Wheeler — ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 124
Primary Registration District No. 2204
(No. ..... St.)

File No. 15784
Registered No. 23

1. PLACE OF DEATH.
County of Kootenai
City of Harrison
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pearl Zorb.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Feb. (Month) 15 (Day) 1881 (Year)
7. AGE: 35 Yrs. 6 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Kans.
10. NAME OF FATHER: P. P. Skidmore
11. BIRTHPLACE OF FATHER (State or Country):
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. P. Zorb
(Address) Harrison Ida.
15. Filed Nov 9 1916 R. S. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1916, to Aug 29 1916, that I last saw her alive on Aug 29 1916, and that death occured on the date stated above, at 8.30 P.M.

The CAUSE OF DEATH* was as follows:
Hypertrophic Cirrosis of liver
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Paralysis Hemorrhage of Brain
(Duration yrs. mos. ds.
(Signed) J. W. Finney M. D.
Aug 30 1916 (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Harrison Ida — DATE OF BURIAL: Aug 30 1916
20. UNDERTAKER: E. O. Wheeler — ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24653

County of Ada — Registration District No. [illegible]

City of Meridian — Primary Registration District No. 2003

(No. ..... St.)

BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
File No. 15785
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl Bok

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male | 4. COLOR OR RACE: White | 5. Single, Married, Widowed or Divorced (Write the Word): Widowed

6. DATE OF BIRTH. Jan 31 1831 (Month) (Day) (Year)

7. AGE. 85 Yrs. 9 Mos. 13 ds. IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION.
(a) Trade, profession or partcular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE. (State or Country) Germany

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) August Hackett
(Address) Meridian #11

15. Filed Oct 14 1916 O. L. Dutton Local Registrar.

Place Where Remains are to be Sent: Pequot Minnesota | Date of Shipment: Oct 16 1916

SHIPPING UNDERTAKER

ADDRESS Meridian Idaho Firm Name W. S. Mateer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 13 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 191..., to Oct 11 1916, that I last saw h[illegible] alive on Oct 11 1916, and that death occurred on the date stated above, at 12 P. M.

The CAUSE OF DEATH was as follows:
Mitral regurgitation and from Fall which caused Infarct. Cerebri

..... (Duration) ~~Years~~ ~~mos.~~ ~~ds.~~

Contributory (Secondary) .....

..... (Duration) 1 Years ..... mos. ..... ds.

(Signed) J. F. Neal M. D.

Oct 14 1916 (Address) Meridian Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Sucidial or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)
At place ..... In the
of death ..... yrs. ..... mos. ..... days State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death .....

Former or usual residence .....

19. ~~PLACE OF BURIAL~~ OR REMOVAL Pequot Minn. | Date of Burial 10/18 1916

20. UNDERTAKER ..... Address .....

The information on this certificate is an exact COPY of the official certificate filed at place of death.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ..... , ... St.)

File No. 15786
Registered No. 46
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ina Perrin Coulter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 14 (Day) 1893 (Year)

7. AGE: 23 yrs. 3 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: J. C. Perrin

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Julia Bennett

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Coulter
(Address) Alexander Idaho

15. Filed Oct 29 1916 D. M. Tandy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1916, to Oct 29 1916, that I last saw her alive on Oct 29 1916, and that death occurred on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:
Hemorrhage resulting from rupturing ectopic gestation
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) -
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. McGourty M. D.
Oct 29 1916 (Address) Drofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Drofino Ida — DATE OF BURIAL: Nov 1 1916

20. UNDERTAKER: W. E. Stoddard — ADDRESS: Kiffford Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada — Registration District No. 11

City of Meridian — Primary Registration District No. 2003

(No. [redacted], St.)

File No. 15788

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mathew Howey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. June (Month) 21 (Day) 1872 (Year)

7. AGE 24 Yrs. 3 Mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Putnam Co Missouri

10. NAME OF FATHER Valley Howey

11. BIRTHPLACE OF FATHER (State or Country) Putnam Missouri

12. MAIDEN NAME OF MOTHER Mary [illegible]

13. BIRTHPLACE OF MOTHER (State or Country) Putnam Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Valley Howey

(Address) Meridian Idaho

15. Filed Oct 17th 1916. C. L. Dutton Local Registrar

PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1916, to Oct 16 1916, that I last saw h[illegible] alive on Oct 16 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

[illegible]

Diabetes Mellitus

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Neal M. D.

Oct 17 1916 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL [redacted] DATE OF BURIAL .....191.....

20. UNDERTAKER W S Mathews ADDRESS Meridian Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
File No. 15789
Registered No. .....

1. PLACE OF DEATH.
County of Ada
City of Meridian
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information. R.D. 2 Near Lower Fairview

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert B Murray.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: American White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH.
April (Month) 7 (Day) 1838 (Year)

7. AGE
78 Yrs. 6 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Kentucky

10. NAME OF FATHER wm Murray

11. BIRTHPLACE OF FATHER
(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER not obtainable

13. BIRTHPLACE OF MOTHER
(State or Country) not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J.A. Murray
(Address) Nampa

15.
Filed Oct-10th 1916
C.L. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from was called 191..., to and found dead 191...
that I last saw him alive on Dec 8 1915,
and that death occured on the date stated above, at 10 a. M.
The CAUSE OF DEATH* was as follows:
Apoplexy
Had stroke one year ago
(Duration) 1 Yrs. — mos. — ds.
Contributory (Secondary) .....
(Duration ... yrs. ... mos. ... ds.
(Signed) Frank R Dayer M. D.
1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? .....
Former or usual residence Nampa Ida

19. PLACE OF BURIAL OR REMOVAL: To Caldwell Ida
DATE OF BURIAL: Oct-11th 1916

20. UNDERTAKER: F.E. Robinson
ADDRESS: Nampa.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 11

Primary Registration District No. 2003.

(No. ..... St.)

File No. 15790

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John B Headrick

If death occurred in a hospital, institution or camp, give NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: November (Month) ..... (Day) 1857 (Year)

7. AGE: 65 Yrs. 4 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Glascow

10. NAME OF FATHER: John W. Headrick

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. O. Headrick

(Address) Boise Idaho RD 2.

15. Filed Aug 26 1916. C. L. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1914 ~~1911~~, to Aug 24 1916, that I last saw him alive on Aug 23 1916, and that death occured on the date stated above, at 8:00 A.M.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

Chronic Interstitial Nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Sutton M. D.

19 ..... (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Idaho — DATE OF BURIAL: Aug 25 1916

20. UNDERTAKER: W. S. Mateer — ADDRESS: Meridian Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15791

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Meridian

(No. ....., ... St.)

Registration District No. 11

Primary Registration District No. 2003

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Felix Newton Ferrell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 17th (Day) 1846 (Year)

7. AGE: 70 Yrs. 3 Mos. 1 day

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kentucky.

10. NAME OF FATHER: John Ferrell.

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James G Ferrell

(Address) Meridian R D 2.

15.

Filed Aug. 17 1916

C. L. Sutton
Local Registrar

SYMS - YORK CO., PTRS. & MFRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 18th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 12th 1916, to Aug-18- 1916, that I last saw him alive on August-17- 1916, and that death occured on the date stated above, at 3.25 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (Uraemic Poisoning)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Spotted Fever April 1915

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Sutton M. D.

19..... (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: 8/19th 1916

20. UNDERTAKER: James G Ferrell Acting

ADDRESS: Meridian R.D.2.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
(No. ....., ... St.)

File No. 15792
Registered No. .....

1. PLACE OF DEATH.

County of Ada
City of Meridian Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Calvin C. Jones.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	American	Married.

6. DATE OF BIRTH.

Feb. (Month) 7 (Day) 1831 (Year)

7. AGE

85 Yrs. 7 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Virginia

10. NAME OF FATHER James Jones.

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Lorenda Warren

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M L Mussey
(Address) Meridian Idaho

15.

Filed Sep 8th 1916 C. L. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1916, to Sept 8 1916, that I last saw h— alive on Sept 7 1916, and that death occured on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Kidney 7 yrs -

(Duration) ..... Yrs. 1 mos. — ds.

Contributory (Secondary) —

(Duration — yrs. 6 mos. ..... ds.

(Signed) Simon L Cuyler M. D.

19..... (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 13 yrs. 6 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?.....

Former or usual residence Miss & Va

19. PLACE OF BURIAL OR REMOVAL: Morris Hill - Boise — DATE OF BURIAL: Sept 9 1916

20. UNDERTAKER: W J Mateer — ADDRESS: Meridian

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGRS. 24659

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15793
Registered No. 43

1. PLACE OF DEATH.
County of Bannock
City of Alexander
(No. ..... St.)
Registration District No. .....
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stella M Mason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Aug. (Month) 25 (Day) 1887 (Year)
7. AGE: 29 Yrs. 1 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Utah
10. NAME OF FATHER William Wright.
11. BIRTHPLACE OF FATHER (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Mary Jane Baum
13. BIRTHPLACE OF MOTHER (State or Country) Provo Utah.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elsie Kunz
(Address) Sedan Oneida Co Ida
15.
Filed Oct 16 1916 Elsie Kunz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 1 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1916, to Oct 1, 1916, that I last saw her alive on Oct 1, 1916 and that death occured on the date stated above, at 7.45 P. M.
The CAUSE OF DEATH* was as follows:
Puerperal Shock
following Operation
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Miscarriage at 3½ Mo.
(Duration ..... yrs. 3½ mos. ..... ds.
(Signed) Elsie Kunz M. D.
Oct 3 1916 (Address) Sedan Oneida Co

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallsburg Utah. DATE OF BURIAL: Oct 6 1916
20. UNDERTAKER: Larkin & Sons Co ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2048
File No. 15795
Registered No. 41

1. PLACE OF DEATH.
County of Bannock
City of Grace (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pietro Russi

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Don't Know

6. DATE OF BIRTH. (Month) Don't Know (Day) 1 (Year)

7. AGE: About 40 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): Labor

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. Fanny
(Address) Grace, Ida

15. Filed Oct 10, 1916 Dis Kurey Local Registrar

SYMS - YORK CO., PTGS. & BDGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep 29. (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 29 1916, to Sep 29. 1916, that I last saw him alive on Sep 29. 1916 and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia
Right Side
(Duration) ..... Yrs. ..... mos. 4 days

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Elias Kaneff M. D.
Sep 29 1916 (Address) Soda Springs, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grace — DATE OF BURIAL: Oct 1, 1916

20. UNDERTAKER: John Allsop — ADDRESS: Grace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2048
File No. 15796
Registered No. 41

1. PLACE OF DEATH.
County of Bunnock
City of Lava Hot Springs (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lenard Walker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept. (Month) 17. (Day) 1902 (Year)

7. AGE: 14 Yrs. 1 Mos. 12 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Rancher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Chas H. Walker

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Ellen Marshall

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas H. Marshall
(Address) Lava Hot Springs Ida

15.
Filed Oct 29 1916 Eric Kinney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 28. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1916, to Oct 28 1916, that I last saw h[illegible] alive on Oct 28 1916, and that death occured on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows: Thrown from a horse sustaing fracture of skull

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) a

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Eric J Kinney M. D.

Oct 29 1916 (Address) Lava Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos..1..days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lava Hot Springs — DATE OF BURIAL: Oct 31 1916

20. UNDERTAKER: Ed Whelan — ADDRESS: Lava Springs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2048
(No. ....., ... St.)

File No. 15797
Registered No. 70

1. PLACE OF DEATH.
County of Bannock
City of Grace
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nick Dach

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Dont Know

6. DATE OF BIRTH. Dont Know (Month) 1 (Day) (Year)

7. AGE: Years Dont Know 35 Mos. ..... ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): Laber

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Thebo
(Address) Grace

15. Filed Oct 27 1916 Ellis Kinsey Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dont Know (Month) ..... (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191, to ..... 191, that I last saw h alive on ..... 191, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Killed by Dynamite Accidently

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ellis Kinsey M. D.

Oct. 19/16 (Address) Soda Springs Idh

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grace — DATE OF BURIAL: Oct 28/ 1916

20. UNDERTAKER: John Allen — ADDRESS: Grace

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15798
Registered No. 89

1. PLACE OF DEATH.
County of Bannock
City of Central
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Brita Catharina Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH
December 3rd 1833
(Month) (Day) (Year)

7. AGE
82 yrs. 10 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) Housework

9. BIRTHPLACE
(State or Country) Sweden

10. NAME OF FATHER
Peha Pehrson

11. BIRTHPLACE OF FATHER
(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Johnson
(Address) Lund

15.
Filed October 10 1916 J. Geo. Kutteres
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
October 10 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lund	Oct. 12 1916

20. UNDERTAKER	ADDRESS
H C Johnson	Lund

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15799

Registered No. 28

1. PLACE OF DEATH.

County of Bannock

City of ~~Pocatello~~ Alexander

Registration District No. 11

Primary Registration District No. 2048

(No. ~~Street Number~~ Bower St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Archie Anderson Bowen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. November (Month) 4 (Day) 1916 (Year)

7. AGE: ....Yrs. 10 Mos. 22 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Alexander Idaho

10. NAME OF FATHER: Geo A Bowen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Madia Warner

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. A. Bowen

(Address) .....

15. Filed Nov 16 1916 Dees Rasey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....191....., to .....191....., that I last saw h.....alive on .....191....., and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....d

(Signed) .....M. D.

.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: ~~Duncan~~ Spanish Fork — DATE OF BURIAL: Sept 28 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2041
File No. 15800
Registered No. 87

1. PLACE OF DEATH.
County of Bannock
City of Grant Ward
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hannah Elizabeth Bowman Dewey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
October (Month) 19 (Day) 1855 (Year)

7. AGE
60 Yrs. 10 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farm Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Utah

10. NAME OF FATHER Hyrum W. Bowman

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER Hannah Wilson

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15.
Filed Nov 10 1916 Ellis Kay
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1916, to Sept 8 1916, that I last saw her alive on Sept 8 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach
(Duration) ..... Yrs. 8 mos. — ds.
Contributory (Secondary) Carcinoma
(Duration 20 yrs. mos. ds.
(Signed) [illegible] M. D.
1916 (Address) Downey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Downey Id — DATE OF BURIAL: Sept 10 1916

20. UNDERTAKER: Dent Kerr — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-20 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2097
File No. 15801
Registered No. 86

1. PLACE OF DEATH.
County of Bannock
City of McCammon (No. South of Inn. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Della Myrtle Lish

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
July (Month) 21 (Day) 1896 (Year)

7. AGE
20 Yrs. 1 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE
(State or Country) Nebraska

10. NAME OF FATHER: Thos D Lewis

11. BIRTHPLACE OF FATHER
(State or Country) Virginia

12. MAIDEN NAME OF MOTHER: Mary Rogers

13. BIRTHPLACE OF MOTHER
(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Neal Lish
(Address) McCammon Ida.

15.
Filed Nov 10 1916 Reis Casey
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29 1916, to Sept 5 1916, that I last saw her alive on Sept 4 1916, and that death occured on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:
Intestinal obstruction of bowels
Secondary to strictures from acute

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. McDill M. D.
Sept 6 1916 (Address) McCammon.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCammon Cem — DATE OF BURIAL: Sept 6 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 45 15802

Registered No.

1. PLACE OF DEATH.

Registration District No. 53

Primary Registration District No. 2

County of Bear Lake

City of Paris

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roland H Rich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: July (Month) Fifth (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. Three ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Paris Bear Lake County

10. NAME OF FATHER Milando P. Rich

11. BIRTHPLACE OF FATHER (State or Country) Paris Idaho

12. MAIDEN NAME OF MOTHER Clara E Koford

13. BIRTHPLACE OF MOTHER (State or Country) Weston Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Milando P Rich
(Address) Paris Ida

15.
Filed 11—14—1916 R J Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) Fifth (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

premature.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. W. Lyon M. D.

19 ..... (Address) Montpelier Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Paris	July 6 1916
20. UNDERTAKER	ADDRESS
Bishop & Sutton	Paris

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Paris
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No. 2132
(No. ..... , ... St.)

File No. 46
Registered No. 15803
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucella Passey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: White
4. COLOR OR RACE: Female
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: 22 October (Month) (Day) 1842 (Year)

7. AGE: 74 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer): Carpet weaver

9. BIRTHPLACE (State or Country): Isle of White

10. NAME OF FATHER: Wm Theobald

11. BIRTHPLACE OF FATHER (State or Country): Isle of White

12. MAIDEN NAME OF MOTHER: Theobald

13. BIRTHPLACE OF MOTHER (State or Country): Isle of White

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lew M Passey
(Address) Paris Idaho

15. Filed Oct 27 1916 R. J. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20" 1916, to Oct 25 1916, that I last saw her alive on Oct 25 1916, and that death occurred on the date stated above, at 5 25 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach.
9
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas E Sutton M. D.
10 25 19 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: DATE OF BURIAL: Oct 27 1916

20. UNDERTAKER: By Parkinson ADDRESS: Paris

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15804

Registered No. 18

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 2112

Primary Registration District No. 86

(No. ..... , ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Della Townley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug. (Month) 20th (Day) 1 (Year)

7. AGE: 31 Yrs. 1 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER John Connell

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maud T. Riggs

(Address) North Powder Oregon

15.

Filed 10-10 1916

W. P. Hamilton
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19 1916, to Oct 9 1916, that I last saw her alive on Oct 9 1916, and that death occured on the date stated above, at 7 p. M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Appendicitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Shirley M. D.

19..... (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Cemetery — DATE OF BURIAL: 10/11 1916

20. UNDERTAKER: Jonathan M Council — ADDRESS: Weiser Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Fruitvale

Registration District No. 1016
Primary Registration District No. 56
(No. ....., ... St.)

File No. 15805
Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Noah Franklin Houston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 22 (Day) 1 (Year)

7. AGE: 39 Yrs. 10 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: George Houston

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Maud R. Royston
(Address) Weiser Ida.

15. Filed 10-14 1916 W. R. Hamilton Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1916, to Oct 12 1916, that I last saw him alive on Oct 12 1916, and that death occured on the date stated above, at 10 00 P. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos.

(Signed) James Agnew M. D.
Oct 14 1916 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: Oct 15 1916

20. UNDERTAKER: Thos. Howard McCann — ADDRESS: Weiser Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15806

Registered No. 19

1. PLACE OF DEATH.

Registration District No. 86

Primary Registration District No. 2112

County of Washington

City of Weiser (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kenneth Woodrow Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 4 (Day) 1913 (Year)

7. AGE: 2 yrs. 11 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Howard Johnson

11. BIRTHPLACE OF FATHER (State or Country): Penn'

12. MAIDEN NAME OF MOTHER: Olga Olson

13. BIRTHPLACE OF MOTHER (State or Country): Mich'

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Johns.

(Address) Weiser Idaho

15.

Filed Oct 12 1916

W. P. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 3 1916, to October 10 1916, that I last saw him alive on October 7 1916, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) —

(Duration ..... yrs. 1 mos. ..... ds.

(Signed) James A Young M. D.

Oct 12 1916 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Cemetry — DATE OF BURIAL: Oct 12 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15807

Registered No. 21

1. PLACE OF DEATH.

County of Washington — Registration District No. 2112

City of Weiser — Primary Registration District No. 86

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith May Bruce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	married

6. DATE OF BIRTH.

Sept. (Month) 7 (Day) 1878 (Year)

7. AGE

38 Yrs. / Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farm life

(b) General nature of industry, business, or establishment in which employed (or employer)..... good.

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER O J Tatum

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eld. E Atkinson

(Address) Weiser Ida,

15.

Filed 10-16 1916 W. R. Harrington Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1916, to Oct 1916, that I last saw her alive on Oct 12 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Mitral Valvular disease & Cancer of Liver.

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E V Anderson M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mann's Creek Cemetery	Oct 16 1916

20. UNDERTAKER	ADDRESS
Northam & McCann	Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 215-0
File No. 15808
Registered No. 100

1. PLACE OF DEATH.

County of Bonneville
City of Idaho Falls
(No. 447, Cliff St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anthony Harvey Boomer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. August (Month) 10 (Day) 1863 (Year)

7. AGE: 53 Yrs. — Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Drayman
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Brookfield Nova Scotia.

10. NAME OF FATHER: Alexander Boomer

11. BIRTHPLACE OF FATHER (State or Country): Maine.

12. MAIDEN NAME OF MOTHER: Janet McClellan

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. M. Byron.
(Address) 341 Broadway. Idaho Falls.

15.
Filed Dec 6 1916 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h...alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Aortic Sclerosis

(Duration) 3 Yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) [illegible] M. D.
Oct 19 16. (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cem. DATE OF BURIAL: Sept. 1916

20. UNDERTAKER: [illegible] ADDRESS: Idaho Falls

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15809

Registered No. .....

Registration District No. 77

Primary Registration District No. 2103

1. PLACE OF DEATH.

County of .....

City of .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Drew Harr Shippen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 15 (Day) 1908 (Year)

7. AGE: 8 Yrs. 9 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho Falls Ida.

10. NAME OF FATHER Carlos Wm Shippen

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Nettie L Woodhead

13. BIRTHPLACE OF MOTHER (State or Country) Utah Utd [redacted]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carlos W. Shippen

(Address) Idaho Falls Idaho

15.

Filed Nov 6 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h.....alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gunshot Wound Abdomen

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Cleff M Rice M. D.

19..... (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cem

DATE OF BURIAL: Sept. 1916

20. UNDERTAKER: W A Lundell

ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

Ihine

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2110
(No. ..... St.)

File No. 15810
Registered No. 97

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella S Loverly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 3 ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: John H. Loverly.

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Minnie Cole.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John H. Loverly.
(Address) Rigby Ida - R. F. D. 2.

15.
Filed Nov 7 1916 W. Truman C
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1916, to Oct 5 1916, that I last saw her alive on Oct 4 1916, and that death occured on the date stated above, at 9P M.

The CAUSE OF DEATH* was as follows:

1 Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lee Clair M. D.
Nov 6 1916 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: United Mortuary
DATE OF BURIAL: Oct. 6 1916

20. UNDERTAKER: W. H. Judd.
ADDRESS: Idaho Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 73

Primary Registration District No. 2130

(No. General Hosp. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15811

Registered No. 96

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

2. FULL NAME Nora L Kerr Randall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Apr (Month) 29 (Day) 1896 (Year)

7. AGE: 70 Yrs. 5 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Edward Kerr

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Emma Whipple

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Kerr

(Address) R D 2 Rigby

15. Filed Nov. 1 1916 C E Emmett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1916, to Oct 18 1916, that I last saw her alive on Oct 18 1916, and that death occured on the date stated above, at 10 a M.

The CAUSE OF DEATH* was as follows:

General Peritonitis

Septicaemia

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Self Induced Abortion

(Duration ... yrs. ... mos. ... ds.

(Signed) C E Emmett M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby Idaho — DATE OF BURIAL: 10/20/1916

20. UNDERTAKER: C E Dinwoodey — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15812

Registered No. 91

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH.

Registration District No. 73

Primary Registration District No. 7170

County of Bannock

City of Idaho Falls

(No. Emergency Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Simeon Allen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Oct (Month) 6 (Day) 1859 (Year)

7. AGE: 57 Yrs. x Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Morley

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Clarence Allen
(Address) Ozone, Idaho

15. Filed Nov 1 191 6 C. E. Hummel Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 17 1916, to Oct. 10, 1916, that I last saw h.... alive on Oct. 10, 1916, and that death occured on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows:
Pernicious anemia
Indefinite (Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) Jno. J. Mella M. D.
19.... (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iona Ida — DATE OF BURIAL: 10/13 1916

20. UNDERTAKER: C. C. Dunwoody — ADDRESS: Idaho Falls

EVANS - YORK CO., PTRS. & STRS. 24853

Dr Mella

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15813

Registered No. 74

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

(No. ....., ... St.)

Registration District No. 73

Primary Registration District No. 2150

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Smith Norman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. ? (Month) ? (Day) 1 (Year)

7. AGE: about 80 yrs ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Jamie A Smith

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Mary Bailey

13. BIRTHPLACE OF MOTHER (State or Country): Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Smith

(Address) Salt Lake City.

15. Filed Nov 1 1916

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) ~~14~~ 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 5, 1916, to Oct. 13, 1916, that I last saw h.er alive on Oct. 12, 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis

Indefinite (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jno. O. McCall M. D.

19..... (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City.

DATE OF BURIAL: 10/16 1916

20. UNDERTAKER: C E Dinwoodey

ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15814

Registered No. 98

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls.

Registration District No. 73

Primary Registration District No. 2150

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Smith.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct. (Month) 27 (Day) 1916. (Year)

7. AGE: 0 Yrs. 38 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER I. L. Smith.

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Vena. Steed

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) I. L. Smith.

(Address) Idaho Falls Ida.

15.

Filed Nov 6 1916 Geo. J. [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 5 (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-3 1916, to 11-4- 1916, that I last saw her alive on 11-4- 1916, and that death occured on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Measles

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary)

.....(Duration .....yrs. .....mos. .....ds.

(Signed) H. C. Hollister M. D.

19.... (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rose Hill Cem. DATE OF BURIAL Nov 6 1916.

20. UNDERTAKER W. J. Judd. ADDRESS Idaho Falls Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15815

Registered No. 93

1. PLACE OF DEATH.

County of Bonneville

City of Ida Falls

(No. Emergency Hosp St.)

Registration District No. 73

Primary Registration District No. 2103

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adam Sauer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 7 (Day) 1865 (Year)

7. AGE: 51 Yrs. 3 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Real Estate Dealer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: John Adam

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Katherine Knopp

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Adam Sauer

(Address) Ida Falls Ida

15.

Filed Nov 1 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1916, to Oct. 10, 1916, that I last saw him alive on Oct. 9, 1916 and that death occured on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis

(Duration) Indefinite Yrs. mos. ds.

Contributory (Secondary) Pulmonary tuberculosis & renal insufficiency

(Duration Indefinite Yrs. mos. ds.

(Signed) Jno O'Meara M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: 10/14 1916

20. UNDERTAKER: C E Dinwoodey — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24858

Mr Mellon

FO[illegible]

CERTIFICATE OF DEATH.

State of I[illegible]
BOARD OF H[illegible]
Bureau of Vital [illegible]

Registration District No. 73
Primary Registration District No. 2150
(No. ..... St.)

File No. 15[illegible]
Registered No. 92

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bannock
City of Ida Falls

2. FULL NAME Harry M. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH. Aug. 24 1905
(Month) (Day) (Year)

7. AGE 11 Yrs. 1 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho Falls Ida

10. NAME OF FATHER Charles Smith

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Alma Carlson

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE GIVEN TO THE BEST OF MY KNOWLEDGE.
(Informant) [illegible]
(Address) Ida Falls Ida

15.
Filed Nov 1 1916 [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 7 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1916, to Oct 7 1916, that I last saw h[illegible] alive on Oct 7 1916 and that death occured on the date stated above, at 8.30 [illegible]

The CAUSE OF DEATH* was as follows:
Headache from acute indigestion and intestinal irritation
(Duration) ..... Yrs. ..... mos. 2
Contributory (Secondary) Cerebral Hemorrhage
(Duration) One hour Yrs. ..... mos. .....
(Signed) W W Pendleton M.D.
Oct 1916 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	10/10 1916
20. UNDERTAKER	ADDRESS
C C Dunwoody	Ida Falls

WRITE PLAINLY, WITH INK—DO NOT USE LEAD PENCIL. MARGINS RESERVED FOR BINDING.
N. B.—Every item of information should be carefully supplied, as the record is PERMANENT RECORD. should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STIMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15817

Registered No. 91

Registration District No. 73

Primary Registration District No. 2170

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls (No. General Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert a Craig

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Married (Write the word.)

6. DATE OF BIRTH. March 4 1831 (Month) (Day) (Year)

7. AGE 85 Yrs. 7 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Stock Raising & Farming
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER Robert Craig

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. R A Craig
(Address) City

15. Filed Nov 1 1916 Colly Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 14 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21st 1916, to Oct 14th 1916, that I last saw him alive on Oct 14th 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senile Debility.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hollister, M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Idaho Falls — DATE OF BURIAL 10/7 1916

20. UNDERTAKER C E Dunwoody — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15818

Registered No. 90

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2170

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Otto Benson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June ? 1898
(Month) (Day) (Year)

7. AGE: 18 Yrs. 4 Mos. ? ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: Saml. B Benson

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Christina Saustad

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S B Benson
(Address) Black Duck, Minn

15.
Filed Nov 1 1916 C. L. Emmons
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 17th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 5P M.

The CAUSE OF DEATH* was as follows:
Accidental. Caught in the
Cylinder of Horse Power
Threshed. 10 mi. West Ida Falls

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C C Dunwoody Coroner
19.... (Address) Ida Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Block Duck — DATE OF BURIAL: 10/22/16

20. UNDERTAKER: C C Dunwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15819

Registered No. 71

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls (No. ..... St.)

Registration District No. 73

Primary Registration District No. 2170

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Jane Hartley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. June (Month) 27 (Day) 1842 (Year)

7. AGE: 74 Yrs. 3 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Thomas Pearson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Ann Reed

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph Hartley
(Address) .....

15.
Filed Nov 1 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1916, to Oct 25 1916, that I last saw her alive on Oct 24 1916 and that death occured on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. P. Soderquist M. D.
10/28 1916 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: 10/27 1916

20. UNDERTAKER: C E Dimmock — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

Dr Soderquist

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 15820
Registered No. 17

1. PLACE OF DEATH.
County of Elmore
City of Mountain Home
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julia Ann Voiles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH.
Dec. (Month) 31 (Day) 1849 (Year)

7. AGE
66 Yrs. 9 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) Iowa

10. NAME OF FATHER Samuel Millsaple

11. BIRTHPLACE OF FATHER
(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Hannah Whitlow

13. BIRTHPLACE OF MOTHER
(State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs R M. Wheeler
(Address) Mountain Home Idaho

15.
Filed Oct. 22nd 1916
B W Mather
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy

about (Duration) Three Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Hawley Former M. D.
10/22/1916. (Address) Mtn Home, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. about 1 yrs. 6 mos. ..... days
In the State. about 1 yrs. 6 mos. ..... days
Where was disease contracted if not at place of death? Iowa
Former or usual residence Iowa

19. PLACE OF BURIAL OR REMOVAL: Steamboat Rock Iowa
DATE OF BURIAL ..... 191...

20. UNDERTAKER: J. M. Cowen
ADDRESS: Mountain Home, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STRS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 15821
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Enid Beverley Schmid

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. ~~SINGLE, MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.): Infant

6. DATE OF BIRTH: Mar. (Month) 31 (Day) 1916 (Year)

7. AGE: ..... yrs. 7 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): Bear Lake

9. BIRTHPLACE (State or Country): Montpelier

10. NAME OF FATHER: Charlie Schmidt

11. BIRTHPLACE OF FATHER (State or Country): Bear Lake

12. MAIDEN NAME OF MOTHER: Marcha Jubille Deem

13. BIRTHPLACE OF MOTHER (State or Country): Grey Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. H. Lynn
(Address): Montpelier Idaho

15.
Filed 11/1 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1916, to Oct 26 1916, that I last saw her alive on Oct 26 1916 and that death occurred on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:
Bronchitis

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Lynn M. D.
10/27 1916 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Montpelier — DATE OF BURIAL: 10/29 1916

20. UNDERTAKER: Larsen — ADDRESS: Montpelier

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
(No. .... St.)

File No. 15822
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harlan J. Hickman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Oct. 1st 1916 (Month) (Day) (Year)
7. AGE: ..... Yrs. ..... Mos. 15 Ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Montpelier Ida.
10. NAME OF FATHER: Thos. F. Hickman
11. BIRTHPLACE OF FATHER (State or Country): Neb.
12. MAIDEN NAME OF MOTHER: Eva Williams
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thos. F. Hickman
(Address) Montpelier Ida
15. Filed 10/17/1916 N. H. Kling Jr. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 16th 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 14th 1916, to Oct 16th 1916, that I last saw h alive on Oct 16th 1916, and that death occured on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Patent Foramen Ovale
(Duration ..... yrs. ..... mos. 3 ds.
(Signed) N H Kling M. D.
10/17 1916 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier — DATE OF BURIAL: 10/19/1916
20. UNDERTAKER: Barbour — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 52

County of Montpelier, Primary Registration District No. 2136 File No. 15823

City of Idaho (No. ....., ... St.) Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maxine Amy Napper

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1916 (Year)

7. AGE: 4 hrs. ..... yrs. ..... mos. ..... da.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montpelier Idaho

10. NAME OF FATHER: David Byron Napper

11. BIRTHPLACE OF FATHER (State or Country): Logan Utah

12. MAIDEN NAME OF MOTHER: Amy Elizabeth Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Bunnington Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Byron Napper
(Address) Montpelier Idaho

15. Filed 11/1/1916 H H Rees Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1916, to Oct 12 1916, that I last saw her alive on Oct 12 1916, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

4 hours

Prematurity Birth ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H H Rees M. D.

Oct 1 1916 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier — DATE OF BURIAL: Oct 17 1916

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 15824
Registered No. .....

1. PLACE OF DEATH.

County of Bear Lake
City of Montpelier
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ola Guthrie

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Don't Know
(Month) (Day) 1 (Year)

7. AGE Don't Know
.....Yrs.....Mos.....ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Sheepherder
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) D. K.

10. NAME OF FATHER
D. M. Guthrie

11. BIRTHPLACE OF FATHER
(State or Country) D.K.

12. MAIDEN NAME OF MOTHER D.K.

13. BIRTHPLACE OF MOTHER
(State or Country) D.K.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. M. Williams
(Address) Montpelier, Idaho

15.
Filed 11/1/1916
H. H. King M.D.
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....1916....., to .....1916.....,
that I last saw h.....alive on .....1916.....,
and that death occured on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
Pneumonia
Complications
Heart Disease
(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary) (Probably Homicidal)
(Duration .....yrs. .....mos. .....ds.
(Signed) .....M. D.
1916 (Address) .....

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hillsboro, Iowa	Oct. 13 1916
20. UNDERTAKER F. M. Williams	ADDRESS Montpelier

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 52

Primary Registration District No. 2136

File No. 15825

County of Bear Lake

City of Montpelier (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Orman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 4 (Day) 1916 (Year)

7. AGE: ..... Yrs. 6 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER: A. M. Orman

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Minnie Amelang

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A M Orman

(Address) Boise, Idaho

15. Filed 11/1/1916, [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Sept~~ Oct (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1916, to Oct 4 1916, that I last saw him alive on Oct 4 1916, and that death occured on the date stated above, at 3:10 P. M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Malnutrition

(Duration) ..... yrs. 5 mos. ..... ds.

(Signed) J. M. Lynn M. D.

Oct 4 1916 (Address) Montpelier Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? Transient.

Former or usual residence Same.

19. PLACE OF BURIAL OR REMOVAL: Ottumwa, Iowa — DATE OF BURIAL: Oct. 7 1916

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 15826
Registered No. .....

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Jonely

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Oct. 2nd 1840
(Month) (Day) (Year)

7. AGE: 76 Yrs. ..... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Switzerland

10. NAME OF FATHER Tribole

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ora Jonely
(Address) Montpelier Ida

15. Filed 10/4/ 1916. J. W. King
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 3rd 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1916, to Oct 3 1916,
that I last saw h..... alive on ..... 191.....
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cancer Stomach
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) L. F. A. Hollenbeck M.D.
10/4 1916 (Address) Paris Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida
DATE OF BURIAL: Oct 6th 1916

20. UNDERTAKER: F. Sarbach
ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2136
File No. 15827
Registered No. .....

1. PLACE OF DEATH.
County of Bear Lake.
City of Montpelier.
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nellie Davis.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.
6. DATE OF BIRTH. July (Month) 13 (Day) 1890 (Year)
7. AGE: 26 Yrs. 3 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): England.
10. NAME OF FATHER: Don't Know.
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Don't Know.
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. M. Coryner
(Address) Mont Peliers
15. Filed 10/31/1916 H H Ling Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1916, to Oct 24 1916, that I last saw her alive on Oct 27 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) 15 Yrs. — mos. — ds.

Contributory (Secondary) Nephritis

Acute pneumonia (Duration) ..... yrs. 4 mos. — ds.

(Signed) H. H. Ling M. D.

10/31 1916 (Address) Mont Peliers Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier. DATE OF BURIAL: Oct. 31 1916

20. UNDERTAKER: F. M. Williams ADDRESS: Montpelier.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

15629

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23

Primary Registration District No. 1017-2017

File No. 15828

(No. ..... , ... St.)

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gooding

City of Jerome

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gustave Haberman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1859 (Year)

7. AGE: 57 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.? —

8. OCCUPATION

(a) Trade, profession or particular kind of work... Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)... Carpenter & Farmer

9. BIRTHPLACE (State or Country): Wis Consin

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anton R. Haberman (Son)

(Address) Jerome Idaho

15.

Filed Aug 4 1916

E. D. Piper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191....., that I last saw h... alive on ..... 191....., and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Suicide by Hanging

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Melancholia

(Duration ..... yrs. 2 mos. ..... ds.

(Signed) E. D. Piper M. D.

Aug 4 1916 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetery — DATE OF BURIAL: Aug 6 1916

20. UNDERTAKER: L. A. L'Heureux — ADDRESS: Jerome Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 1010

Primary Registration District No. 86

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15829

Registered No. 24

1. PLACE OF DEATH.

County of Washington

City of Weiser

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Etta A. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 8 (Day) 1862 (Year)

7. AGE: 54 Yrs. 1 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New Brunswick Canada

10. NAME OF FATHER Fredrick Dunphy

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Albina Hawkins

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R T Black

(Address) 407 E Main Weiser Ida

15.

Filed 11-27 1916

W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 27th 1916. 191
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 20 1916, to November 27 1916, that I last saw her alive on Nov 27 1916, and that death occured on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Dilatation of The Heart

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.

11/27/1916 (Address) Weiser, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Cemetery — DATE OF BURIAL: 11/29 1916

20. UNDERTAKER: Jos Ham & M Conn — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. [illegible] 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 1010

Primary Registration District No. 86

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15830

Registered No. 23

1. PLACE OF DEATH.

County of Washington

City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fermus J. Packer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. March (Month) ..... (Day) 1 (Year)

7. AGE: 63 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Harmon J. Packer

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Malcom S Packer

(Address) Payette, Idaho

15. Filed Nov 26th 1916 W. R. Hamilton — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 28th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22nd 1916, to Nov 25th 1916, that I last saw h[illegible] alive on Nov 25th 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy.

..... (Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.

19..... (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: 11/27 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD:

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15831

Registered No. 22

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Howrey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Dec (Month) 7 (Day) 1867 (Year)

7. AGE
49 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Richard Howrey

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Sarah Cull

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Richard Howrey
(Address) Weiser Idaho

15.
Filed 11-13 1916 W. P. Hamilton Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6 1916, to Nov 10 1916, that I last saw him alive on Nov 10 1916, and that death occured on the date stated above, at 7 10 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
+ Pneumonia.

(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Chronic Stomach

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. T. Anderson M. D.
Nov 13 1916. (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: Nov 13 1916

20. UNDERTAKER: Northam & McCown — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM [illegible] M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 125
Primary Registration District No. 2203
(No. ....., ... St.)

File No. 15832
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of Dubois
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elving H Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 3 (Day) 1886 (Year)

7. AGE: 30 Yrs. 7 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER John Pearson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Christene Nelson

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anna Johnson
(Address) Dubois Idaho

15. Filed Nov 22 1916 H E Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h.....alive on ..... 191...,
and that death occured on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:
Right Chest crushed.
Instantly killed — fell from load of hay
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H E Jones M. D.
11-22 1916 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dubois Idaho
DATE OF BURIAL: Nov. 23 1916

20. UNDERTAKER: None
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15833
Registered No. 275

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anastasio Uberuaga

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. (Month) 17 (Day) 1916 (Year)

7. AGE: ... Yrs. 2 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF FATHER Domingo Uberuaga

11. BIRTHPLACE OF FATHER (State or Country) Spain

12. MAIDEN NAME OF MOTHER Damiana Erquiaga

13. BIRTHPLACE OF MOTHER (State or Country) Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mateo Aregui
(Address) 704 N. 7th St.

15. Filed 11/29 191 6
E. J. Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 28th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20 1916, to Nov 28 1916, that I last saw h[illegible] alive on Nov 28 1916, and that death occured on the date stated above, at 9 30 A.M.

The CAUSE OF DEATH* was as follows:
Inanition due to mal nutrition.

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration ... yrs. 2 mos. ... ds.
(Signed) L. P. McCalla M. D.
19... (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ft Johns Boise Co. DATE OF BURIAL: 11/29 1916
20. UNDERTAKER: Schreiber Hodges Co. ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15834

Registered No. _____

1. PLACE OF DEATH.

County of Ada.

City of Boise.

(No. 803 No 10 St. St.)

Registration District No. _____

Primary Registration District No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Van Deusen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 18 (Day) 1852 (Year)

7. AGE: 64 Yrs. 6 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): New Jersey.

10. NAME OF FATHER: John Durlick.

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Voorhees

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. E. Van Deusen

(Address) Emmett Idaho

15. Filed 11/26 1916 E. J. Cutler Local Registrar

SYMS - YORK CO., PTRS. & BKBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22 1916, to Nov 26 1916, that I last saw her alive on Nov 25 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Adremia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. T. Smith M. D.

11/27 1916 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Nov 27 1916

20. UNDERTAKER: Guy & Lemmon Co. — ADDRESS: Boise.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 15835

Registered No. 273

County of Ada

City of Boise (No. 912 Hutte 10th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lillie M. Wardell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March 31 1869 (Month) (Day) (Year)

7. AGE: Yrs. 47 Mos. 7 ds. 26

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)... Housewife

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Felix Brooks

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Margarete Hunter

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elzy E. Wardell

(Address) 912 N. 10 St

15. Filed 11-26 1916 E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 25 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1 1914, to Nov. 25 1916, that I last saw h alive on Nov 25 1916, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 8 or 10 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Jno. R. Numans M. D.

19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 27 1916

20. UNDERTAKER: Schreiber Heidenfrost — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15836

Registered No. 272

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada.

City of Boise.

(No. 409 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rebecca J King.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Nov (Month) 11 (Day) 1828 (Year)

7. AGE. 88 Yrs. — Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Stephen Jones.

11. BIRTHPLACE OF FATHER (State or Country): Kentuckey.

12. MAIDEN NAME OF MOTHER: Black.

13. BIRTHPLACE OF MOTHER (State or Country): Not Ascertained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. W. King

(Address) —

15. Filed 11-25 191 6 E. Eakin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-14 1916, to 11-24 1916, that I last saw her alive on 11-23 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Maurice D. Fallon M. D.

11/25 1916. (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Nov 26 1916

20. UNDERTAKER: Frey & Lemmon Co. ADDRESS: Boise Ida.

SYMS - YORK CO., PTRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15837

Registered No. 271

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. Eugene Rely St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Essie May Potter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 8 (Day) 1915 (Year)

7. AGE: 1 Yrs. 0 Mos. 15 ds.

IF LESS than 1 day how many.....hrs. or .....min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OR FATHER Ralph Potter

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Bessie Botford

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ralph Potter

(Address) Meridian Idaho

15. Filed 11/24 1916 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 23rd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23rd 1916, to Nov 23rd 1916, that I last saw her alive on Nov. 23rd 1916, and that death occured on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:

Exhaustion due to severe congestive condition -

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) Not - normal from birth

.....(Duration .....yrs. .....mos. .....ds.

(Signed) J. M. Taylor M. D.

Nov 23 1916 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 24 1916

20. UNDERTAKER: Gray Funeral Home — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15838
Registered No. 270

1. PLACE OF DEATH.
County of Ada
City of Boise.
(No. 101 [illegible] St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma L. Barber

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Feb (Month) 8 (Day) 1861 (Year)

7. AGE
55 Yrs. 9 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Indiana.

10. NAME OF FATHER James G. Allison.

11. BIRTHPLACE OF FATHER
(State or Country) Pennsylvania.

12. MAIDEN NAME OF MOTHER Catherine Mann

13. BIRTHPLACE OF MOTHER
(State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Benton Allison Barber
(Address) 6351 Kenwood Av. Chicago

15.
Filed Nov 27 1916
[signature] Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. 24 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16 1916, to Nov 24 1916, that I last saw her alive on Nov 24 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) acute congestion of lungs

(Duration ..... yrs. ..... mos. 3 ds.

(Signed) H. M. Alverson M. D.

19..... (Address) 317 Empire B.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Nov 25 1916

20. UNDERTAKER: Foy & Summers Co. — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 15839
Registered No. 269

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. St Lukes Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Davison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 22 (Day) 1916. (Year)

7. AGE ____ Yrs. ____ Mos. ____ ds. IF LESS than 1 day how many 1 hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer)... —

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER William N. Davison

11. BIRTHPLACE OF FATHER (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Beatrice Head.

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm H Davison
(Address) 322 Idaho Bldg. Boise

15. Filed 11/23 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22 1916, to Nov 22 1916, that I last saw her alive on Nov 22, 16 1916, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration ... yrs. ... mos. ... ds.

(Signed) Geo [illegible] M. D.

11/23 1916. (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Nov. 23 1916

20. UNDERTAKER: Fryer Summers Co. — ADDRESS: Boise Idg.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 603 S. Franklin St.)

File No. 15840

Registered No. 268

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Elouise Knudsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 1st (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Boise, Idaho.

10. NAME OF FATHER Edward E. Knudsen

11. BIRTHPLACE OF FATHER (State or Country) Neb.

12. MAIDEN NAME OF MOTHER Mary Jane Scott

13. BIRTHPLACE OF MOTHER (State or Country) Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward E. Knudsen

(Address)

15. Filed 11-23 191 .....

E. L. Culver
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 22nd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1916, to Nov 22 1916, that I last saw her alive on Nov. 22 1916, and that death occured on the date stated above, at 4. P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

Child unable to nurse sufficiently

Appeared indifferent with Pneumonia

(Duration) ..... Yrs. ..... mos. 22 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Davis M. D.

19..... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov. 24 1916

20. UNDERTAKER: Schreiber & Hedenstedt — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Dr Davis

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15841

Registered No. 267

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Grace L. Wormeler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May 6 (Month) (Day) 1880 (Year)

7. AGE 36 Yrs. 6 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Fulton Co Ohio

10. NAME OF FATHER Soloman Lee

11. BIRTHPLACE OF FATHER (State or Country) Holmes Co Ohio

12. MAIDEN NAME OF MOTHER Ella Miley

13. BIRTHPLACE OF MOTHER (State or Country) Holmes Co Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. N. York

(Address) Meridian

15. Filed 11 Dec 23 1916

E. A. Cowen Ada Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-11 1916, to 11-21 1916, that I last saw her alive on 11-20 1916, and that death occured on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows: Intestinal obstruction due to omental fold

(Duration) Yrs. mos. 8 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Maurice B Tallman M. D.

11/21 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence near Meridian

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov. 23 1916

20. UNDERTAKER: Schreiber & Heidenfelder — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15842

Registered No. 266

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No.

Primary Registration District No. 1004

(No. 612 N 9 St. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert B. Horne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Mar (Day) 12 (Year) 1844

7. AGE: 72 Yrs. 8 Mos. 7 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not obtainable

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E R Horne

(Address) 612 N 9th St

15. Filed 11/27 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Nov (Day) 19th (Year) 1916

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1916, to Nov 19 1916, that I last saw h[illegible] alive on Nov 19 1916, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W B Gault M. D.

11/27 1916 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 22 1916

20. UNDERTAKER: Eggy & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & RGRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15843

Registered No. 265

1. PLACE OF DEATH.

County of Ada

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosalie Brown.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widow.

6. DATE OF BIRTH. Nov 14 1 (Month) (Day) (Year)

7. AGE: 58 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER James G. Allison

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania.

12. MAIDEN NAME OF MOTHER Catherine Mann

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rosalie Brown

(Address) .....

15. Filed 11 17 1916 E. L. Rutan Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13 1916, to Nov 19 1916, that I last saw h[er] alive on Nov 19 1916 and that death occured on the date stated above, at 9.40 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Acute Nephritis

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Stevenson M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Nov 23 1916
20. UNDERTAKER	**ADDRESS**
Fry & Summers Co.	Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15845
Registered No. 263

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha Millemann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. January 3 1866 (Month) (Day) (Year)

7. AGE: Yrs. 50 Mos. 10 ds. 13
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Evansville Ind

10. NAME OF FATHER: Adam Gasser

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Fannie Gasser

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elsie Shuckhard
(Address) San Francisco Cal

15. Filed 11/18 1916 E Mertz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1916, to Nov 16 1916, that I last saw h... alive on Nov 16 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cancer of breast

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Geo Calvert M. D.
19.... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: Nov 19 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 15846
Registered No. 262

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward V. Johnson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 8 (Day) 1863 (Year)

7. AGE: 53 Yrs. 11 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Oregon Linn Co

10. NAME OF FATHER David Johnson

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Belenger

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J A Pendleton
(Address) Cambridge Idaho

15. Filed 11/16 1916 C E Patty Local Registrar

SYMS - YORK CO., PTR. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 15th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1916, to Nov 15, 1916, that I last saw h[illegible] alive on Nov 15 1916, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Intestinal Obstruction
due to Volvulus

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) H B Smith M. D.
11/16 1916. (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 17 1916

20. UNDERTAKER: Schneider & Anderson — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15847
Registered No. 261

Registration District No. 2
Primary Registration District No. 1004
(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ada
City of Boise

2. FULL NAME Norman C. Almond.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec 20 (Month) (Day) 1892 (Year)

7. AGE: 22 Yrs. 10 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Chauffeur.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado.

10. NAME OF FATHER: Frank W Almond.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Julia Jaeger.

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. W. Almond
(Address) 505 So 15 St Boise Ida.

15. Filed 11/17 1916
E. J. Pater
Local Registrar

SYMS - YORK CO., PTRS. & ENGRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
11 (Month) 15 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1916, to Nov 15 1916, that I last saw him alive on Nov 15 1916, and that death occured on the date stated above, at 4 20 P.M.

The CAUSE OF DEATH* was as follows:
Acute endocarditis

(Duration) Yrs. 1 mos. 4 ds.
Contributory (Secondary) Nephritis acute

(Duration yrs. mos. 10 ds.
(Signed) Maynard Fellman M. D.
11/16 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Nov 18 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 1260

1. PLACE OF DEATH

County of Ada

City or Town of Boise

(No. 410 State St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaretta Ellen Gray

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Dec. (Month) 4 (Day) 1867 (Year)

7. AGE: 48 Yrs. 11 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Finch

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hardy Ellen Jenkins

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. L. Gray

(Address) 411 State St. Boise

15.

Filed 11/15 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1916, to Nov 15 1916, that I last saw h[illegible] alive on Nov 15 1916 and that death occured on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:

mitral regurgitation and mitral sclerosis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration 2 yrs. mos. ds.

(Signed) M. H. Tallman M. D.

11/15 1916 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Nov 16 1916

20. UNDERTAKER: Schreiber & Hidenfrau | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. &c. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital St.)

File No. 15849
Registered No. 258

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ada
City of Boise

2. FULL NAME B. J. Nordyke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1830 (Year)

7. AGE: 86 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not Obtainable

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles Anderson
(Address) Boise Ida

15. Filed 11/17 1916
E. L. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1916, to Nov 11 1916, that I last saw h alive on Nov 9 1916, and that death occured on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
General Senility
Senile Dementia

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

11/11 1916 (Signed) [illegible] M. D.
(Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: Nov 12 1916

20. UNDERTAKER: Frye Summers — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 15851

Registered No. 256

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Haines

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Aug (Month) 24 (Day) 1854 (Year)

7. AGE: 61 Yrs. 4 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. F. Haines

(Address) Richfield Idaho

15.

Filed 11/13 191 6

E. A. Cahn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 11 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 191 6, to Nov 11 191 6, that I last saw h... alive on Nov 10 191 6, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cardiac dilitation

Hydrocephalus

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

11/11 19 16 (Signed) James L. Stewart M. D.

(Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Richfield, Idaho

19. PLACE OF BURIAL OR REMOVAL: Richfield Idaho — DATE OF BURIAL: 11/14 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNE - YORK CO., PTRS. & BKBS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15852

Registered No. 255

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 909 N. 16th St.)

Registration District No.

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ann Rickh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 17 (Day) 1858 (Year)

7. AGE: 58 Yrs. 5 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: George Gibbard

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Williams

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W Lewis

(Address) Boise Idaho

15. Filed 11/17 1916

Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 11th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6th 1916, to Nov 11 1916, that I last saw h[er] alive on Nov 11 1916, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Cardiocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W B Smith M. D.

11/17 1916 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence Rexburg Idaho Shyness

19. PLACE OF BURIAL OR REMOVAL: Rexburg Ida — DATE OF BURIAL: Nov 12 1916

20. UNDERTAKER: Schreiber & Hildinfodus — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15853
Registered No. 254

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 121 & Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alfred M Ericson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. — (Month) — (Day) 1870 (Year)

7. AGE: 46 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Not Obtainable

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) [illegible]
(Address) Boise Ida

15. Filed 11/7 1916 E. [illegible] Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: NOV. (Month) 6th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from NOV. 6th 1916, to ..... 191..., that I last saw h[illegible] alive on NOV 6th 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Causing a skull by tongs used in loading saw logs.
(Duration) (11 hours) mos. ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. P. McCalla M. D.
11/6 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Nov 9 1916
20. UNDERTAKER	**ADDRESS**
Fry & Summers Co.	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15854

Registered No. 253

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. St. Luke's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant. Scollard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. (Month) 6 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 2 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Boise Idaho.

10. NAME OF FATHER Chas Scollard

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Lorine Miller

13. BIRTHPLACE OF MOTHER (State or Country) Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Scollard

(Address) Boise Ida

15. Filed 11/8 1916

E. L. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191....,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature birth
about 6 1/2 mos.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Spangler M. D.

Nov 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 9 1916

20. UNDERTAKER: Gray & Summers — ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 15855

County of Ada

City of Boise (No. 410 State St.)

Registered No. 249

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bessie Dacia Merrill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 5th (Day) 1881 (Year)

7. AGE: 35 Yrs. 9 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: William Estes

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Rozaltha Sylvester

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A M Hatch

(Address) Pocatello Ida.

15. Filed 11/7 1916

E J Clifton
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11/2 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1916, to Nov 2 1916 that I last saw her alive on Nov 2 1916 and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ralph Teal M. D.

11/2 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov. 3 1916

20. UNDERTAKER: Pierce & Talmage — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15856

Registered No. 248

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No.

Primary Registration District No. 1004

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Adelaide Lewis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 9 (Day) 1908 (Year)

7. AGE: 8 Yrs. 8 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Silver City Idaho

10. NAME OF FATHER: George N. Lewis

11. BIRTHPLACE OF FATHER (State or Country): Silver City Idaho

12. MAIDEN NAME OF MOTHER: Lela M Carithers

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo N Lewis

(Address) Oreana Ida

15. Filed 11/3 191 6

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 2 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 191 6, to Nov 1 191 6, that I last saw h... alive on Nov 1 191 6, and that death occured on the date stated above, at 30 M.

The CAUSE OF DEATH* was as follows:

Extensive Burn

(Duration) ... Yrs. ... mos. 3 ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) James L Hamm M. D.

11/6 191 6 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oreana Idaho. DATE OF BURIAL: Nov. 4 191 6

20. UNDERTAKER: Frey & Summers ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15857

Registered No. 64

1. PLACE OF DEATH.

County of Ada

Registration District No. 8

Primary Registration District No. 2004

City of Beach, Emita P. O. (If not in city give township) Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clinton T. Hartley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 21 (Day) 1862 (Year)

7. AGE: 54 Yrs. 7 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: William Hartley

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Eliza Painter

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Will Hartley
(Address) Eagle, Idaho

15. Filed Nov 8 1916 E. J. Cahill Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 3rd (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1916, to Nov 3 1916, that I last saw h— alive on Nov 3 1916, and that death occured on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Septic Poisoning
following Gangrene of Intestines
(Duration) Yrs. 1 mos. 5 ds.

Contributory (Secondary) Hernia
(Duration) 54 yrs. mos. ds.

(Signed) R. E. Lynch M. D.
Nov 3 1916 (Address) R. E. Lynch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov. 4 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

File No. 15858

Registered No. 65

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of

(No. 7 Miles West of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Theresa E Terp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 16 (Day) 1864 (Year)

7. AGE: 52 Yrs. ..... Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: James Morris.

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Clarcy. Gill.

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jason Terp
(Address) Boise Idaho

15. Filed Nov 8 1916 E. H. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 4th 1916, to Nov 7th 1916, that I last saw her alive on Nov 7th 1916, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Mitral valvular heart disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cardiac Dropsy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo R Nuckolls M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 9 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2054
File No. 15859
Registered No. 66

1. PLACE OF DEATH.
County of Ada.
City of 2½ miles SW. of Boise (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph B. Eastebrook.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
m.	white.	M

6. DATE OF BIRTH. Apr (Month) 30 (Day) 1857 (Year)

7. AGE 57 Yrs. 6 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Rancher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Michigan

10. NAME OF FATHER Samuel Eastebrook.

11. BIRTHPLACE OF FATHER (State or Country) New York.

12. MAIDEN NAME OF MOTHER Eliza Hammond.

13. BIRTHPLACE OF MOTHER (State or Country) Not Of Record

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Merrill B. Eastebrook
(Address) Boise Idaho

15. Filed Nov 10 1916 E. J. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6 1916, to Nov 8 1916, that I last saw h— alive on Nov 8 1916, and that death occured on the date stated above, at 1730 M.

The CAUSE OF DEATH* was as follows:

Hydrocephaloid

(Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Blunt M. D.
Nov 10 1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Nov 10 1916
20. UNDERTAKER	**ADDRESS**
Frey & Summers	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15860

Registered No. 9

1. PLACE OF DEATH.

County of Ada

City of

Registration District No. 8

Primary Registration District No. 2008

(No. 6 West of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Celice Matheus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 9 (Day) 1875 (Year)

7. AGE: 41 Yrs. 0 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: W W Irish

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Susan M. Bayley

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Guy E Matheus

(Address) RR #1 Boise Ida

15. Filed Nov 19 1916

E. F. Cole
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12 1916 to Nov 18 1916 that I last saw h[illegible] alive on Aug 12 1916 and that death occured on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) Mechanical Colic

(Duration) 1 yrs. — mos. — ds.

(Signed) H Goodrich M. D.

1916 (Address) Eagle

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Nov. 19 1916

20. UNDERTAKER	ADDRESS
Fry & Summers	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2004

File No. 15861

Registered No. 68

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. South Boise St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marietta B. Matthews

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 20 (Day) 1843 (Year)

7. AGE: 73 Yrs. 1 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Croydon Burr

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Electa Buffum

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Guy E. Matthews

(Address) RR #1 Boise Ida

15. Filed NOV 23 1916

E. A. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1916, to Nov 21 1916, that I last saw he'd alive on Nov 21 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

La Grippe

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Parker M. D.

11/23 1916 (Address) Ada County Bldg Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL, OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 24 1916

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR-TRIBUNE PRINTING CO., CASPER, WYO.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2 Ward

(No. County Hospital St.)

File No. 15862

Registered No. 69

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. T. Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Not Known (Month) (Day) 1 (Year)

7. AGE ..... Yrs. 72 Mos. 7 ds. 5

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work... Prospector

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. E. Lynch

(Address) Boise Idaho

15. Filed Nov 27 1916 E. F. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 26 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1916, to Nov 26 1916, that I last saw h[illegible] alive on 26 Nov 1916 and that death occured on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma face

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) R. E. Lynch M. D.

1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	Nov 27 1916
20. UNDERTAKER	**ADDRESS**
Schreibel & Hidenfelder	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15863

Registered No. 70

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Judiths Home

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William T. Burns

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. — (Month) — (Day) 1838 (Year)

7. AGE: 78 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Veteran Indian War

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Not Obtainable

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. F. Burnett

(Address) Judiths Home.

15. Filed Nov 28 1916

E. F. Eater Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 26 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1916, to Nov 26 1916, that I last saw h[illegible] alive on ..... 191..., and that death occured on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Lacy M. D.

Nov 29/16 (Address) Boise Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov. 28 1916

20. UNDERTAKER: Terry & Summerhays — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15864

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Cambridge

(No. ....., ... St.)

Registration District No. 88

Primary Registration District No. 2164

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Laura Courtwright.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 15 (Day) 1916 (Year)

7. AGE: ....Yrs. ....Mos. 11 ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wash & Idaho

10. NAME OF FATHER: Frank Courtwright.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Sarah Benton

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Florence Courtright

(Address) Cambridge Idaho.

15. Filed Nov 16 1916 C E Schmutz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1916, to Nov 26 1916, that I last saw her alive on Nov 15 1916, and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Measles followed by Pneumonia

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) Measles

.....(Duration .....yrs. .....mos. 5 ds.

(Signed) C E Schmutz M. D.

Nov 7 1916 (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho — DATE OF BURIAL: Nov 27 1916

20. UNDERTAKER: Jas Anderson — ADDRESS: Cambridge Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 88
Primary Registration District No. 2164
(No. ....., ... St.)
File No. 15865
Registered No. .....

1. PLACE OF DEATH.
County of Washington
City of Cambridge
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minnie May Bush Carter

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 44 Yrs. 11 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Golden Co, Ohio

10. NAME OF FATHER: Gordon I Bush

11. BIRTHPLACE OF FATHER (State or Country): Pike Co, Ohio

12. MAIDEN NAME OF MOTHER: Sarah M. Gutherie

13. BIRTHPLACE OF MOTHER (State or Country): Golden, Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lela Bush
(Address) Cambridge Ida.

15. Filed Dec 1 1916 C E Schmutz Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1916, to Nov 12 1916, that I last saw her alive on Nov 11 1916, and that death occured on the date stated above, at 3 05 AM.

The CAUSE OF DEATH* was as follows:
Cancer of Liver & Gallbladder

(Duration) Yrs. 3 mos. 20 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C E Schmutz M. D.
Nov 11 1916 (Address) Cambridge Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER: Jas Hendelson | ADDRESS: Cambridge Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 88

Primary Registration District No. 2164

File No. 15866

Registered No. .....

1. PLACE OF DEATH.

County of [redacted] Washington

City of [redacted] Cambridge

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Henry White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 10 (Day) 1873 (Year)

7. AGE: 43 Yrs. 10 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Rancher

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York.

10. NAME OF FATHER John White

11. BIRTHPLACE OF FATHER (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER Martha McMillan

13. BIRTHPLACE OF MOTHER (State or Country) N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lottie Wedig

(Address) Cambridge Idaho

15.

Filed Nov 23 1916

C E Schunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22 1916, to Nov 22 1916, that I last saw him alive on Nov 22 1916, and that death occured on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Fracture of Base of Skull and Jaw.
in a runaway Accident

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C E Schunt M. D.

Nov 22 1916 (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL: Nov 25 1916

20. UNDERTAKER: Jas Gudelsen | ADDRESS: Cambridge Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 88

Primary Registration District No. 2164

File No. 15867

County of .....

City of ..... (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward J. Gibbs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 10 (Day) 1865 (Year)

7. AGE: 31 Yrs. 1 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Dalton Mo.

10. NAME OF FATHER: A Jackson Gibbs

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Minnie Elizabeth Dalton

13. BIRTHPLACE OF MOTHER (State or Country): Carrollton Dalton Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E J Gibbs
(Address) Cambridge Idaho

15. Filed Dec 4 1916 C E Schmutz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1916, to Dec 4 1916, that I last saw him alive on Dec 4 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Gunshot in Center of forehead
death ensued in 45 minutes
This was done in a fit of insanity
(Duration) Yrs. 1 mos. 1 ds.
Contributory (Secondary) Insanity
(Duration unknown yrs. ..... mos. ..... ds.
(Signed) Simpson Douglass M. D.
Dec 4 1916 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida — DATE OF BURIAL: .....191.....

20. UNDERTAKER: J A Anderson — ADDRESS: Cambridge Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 105868
Registered No. 531

Registration District No. 84
Primary Registration District No. 1216

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 455 S. Garfield St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Mercedes J. Brady

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct 21st 1898 (Month) (Day) (Year)

7. AGE: 18 Yrs. — Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Edward Brady

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Elizabeth Kelley

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Bessie Young
(Address) Pocatello Idaho

15. Filed Oct 30, 1916 O. E. Reed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 28th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/28 1916, to 10/28 1916, that I last saw her alive on 10/27 1916, and that death occured on the date stated above, at 6a. M.

The CAUSE OF DEATH* was as follows:

Cardiac [redacted]

(Duration) Yrs. 6 mos. 9 ds.

Contributory (Secondary) Chronic Endocarditis

(Duration) 15 yrs. — mos. — ds.

(Signed) O. G. Wright M. D.

10/30 1916 (Address) Pocatello, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utah — DATE OF BURIAL: Oct 31 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 105869

Registered No. 532

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 84

Primary Registration District No. 2161

(No. General Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Catherine Scott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Feb (Month) 13 (Day) 1862 (Year)

7. AGE: 54 Yrs. 7 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER William Miller

11. BIRTHPLACE OF FATHER (State or Country) Ger Germany

12. MAIDEN NAME OF MOTHER Clarisa Bristol

13. BIRTHPLACE OF MOTHER (State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarice C. Verrand

(Address) Pocatello Idy

15. Filed Nov 1 1916

O P Keeley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 21 1916, to Oct. 30" 1916, that I last saw h[illegible] alive on Oct. 30" 1916, and that death occured on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Septic Abscess

Pericephritic Abscess

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) Pneumothorax

(Duration) yrs. mos. 2 ds.

(Signed) L. M. Sprague M. D.

10-31-1916 (Address) Kate Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Oct 11-1 1916

20. UNDERTAKER: Pocatello Idaho — ADDRESS: 144 No Arthur

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
'BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 15870
Registered No. 502

1. PLACE OF DEATH.
County of Bannock
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jeremiah Sivels

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. about 40 years old ..... (Month) ..... (Day) 1 (Year)
7. AGE: Near as known 40 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) unknown
10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (State or Country) unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. G. Keenan.
(Address) Pocatello Idaho
15. Filed Sept 11, 1916 O. E. Stevens Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 4 a.m. 1916
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Francis M Rose M. D.
9/11 1916 (Address) Conner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View cem — DATE OF BURIAL: Sept 12 1916
20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15871

Registered No. 503

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2101

(No. Gen Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alba Fauro

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Italian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 20 (Day) 1896 (Year)

7. AGE: 20 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Nicola Fauatto

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicola Fauatto

(Address) Pocatello Idaho

15. Filed Sept 6 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 4 1916, to Sept. 5 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gun Shot Wounds

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Sept 6 1916 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem

DATE OF BURIAL: Sept 8 1916

20. UNDERTAKER: Schumacher & Hall

ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2461
File No. 11587
Registered No. 504

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. Jess Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Pimm

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Exact date unknown 1868 (Month) (Day) (Year)
7. AGE: 48 Yrs. Mos. ds. Near as known. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): unknown
10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (State or Country): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (State or Country): unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lanna Lamoreaux
(Address) County Poor Farm
15. Filed Sept 13, 1916 O. F. Steely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8 (Day) 191 6 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept. 1 1916, to Sept 8 191, that I last saw h alive on 191, and that death occured on the date stated above, at M.
The CAUSE OF DEATH was as follows:
Nephritis.
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) L. Smith Warren M. D.
19 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs mos days. In the State yrs mos days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. DATE OF BURIAL: Sept 191
20. UNDERTAKER: Schumacher & Harp ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15873

Registered No. 208

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2164

(No. 636 N. Grant St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella Worel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Apr (Month) 25 (Day) 1867 (Year)

7. AGE: 49 Yrs. 3 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) ~~Nebraska~~ N. Jersey

10. NAME OF FATHER James Gerfield

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Ella Gerfield

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Otto A. Worel.
(Address) Pocatello Idaho

15. Filed Sept 19, 1916 O. R. Cady Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/10 1916, to 9/16 1916, that I last saw her alive on Sept. 16 1916, and that death occured on the date stated above, at 9:30p M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 1 Yrs. 3 mos. ds.

Contributory (Secondary) Typhoid - Fever

(Duration) 2 yrs. mos. 10 ds.

(Signed) W. H. Wright M. D.

9/19 1916 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mountain View | DATE OF BURIAL Sept 20 1916

20. UNDERTAKER Schumacher & Hay | ADDRESS City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 19587
Registered No. 509

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 454 No Main St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lunetty Boggs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 6 (Day) 1877 (Year)

7. AGE: 39 Yrs. 7 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm L. Rice

11. BIRTHPLACE OF FATHER (State or Country): Farmington Utah.

12. MAIDEN NAME OF MOTHER: Mary J. Wair.

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Irene Hoots
(Address) Pocatello Ida.

15. Filed Sept 22 1916 — O R Lewis, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1916, to Sept 19 1916, that I last saw her alive on Sept 19 1916, and that death occured on the date stated above, at 9P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) Several years.
Contributory (Secondary) Hemorrhage of Lungs.
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Kay M. D.
Sept 20 1916 (Address) Pocatello, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cemetery — DATE OF BURIAL: Sept 23 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

BYNS - YORK CO., PTRS. & RGRS. 24654

FORM V. S. No. 5-46 M. 2-16-15

CERTIFICATE OF DEATH

State of Idaho
Board of Health
Bureau of Vital Statistics
File No. 15875

(PLACE OF DEATH)

County of Bannock

Registration District No. 84

Primary Registration District No. 210

City of Pocatello (No. 744 So Hayes St.)

Registered No. 211

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward J Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. December 30 (Month) (Day) 1890 (Year)

7. AGE: 26 Yrs. 8 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Malad Idaho.

10. NAME OF FATHER: Edward Phillips

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Jones

13. BIRTHPLACE OF MOTHER (State or Country): Logan Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs H L West
(Address) Pocatello Idaho

15. Filed Sept 21, 1916 O P Keiser Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1916, to Sept 20 1916, that I last saw him alive on Sept 20 1916, and that death occured on the date stated above, at 1.30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Alcoholism

(Duration ?) ..... yrs. ..... mos. ..... ds.

(Signed) Francis A Poole M. D.

9/21 1916 (Address) City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View Cem	Sept 22 1916
20. UNDERTAKER	ADDRESS
Schumacher & Hall	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

15876

Registration District No. 84
Primary Registration District No. 2161
(No. ....., ... St.)

File No. 10 5
Registered No. 5 1 1

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock
City of Pocatello

2. FULL NAME William J Sanders

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Not known (Month) (Day) 1 (Year)

7. AGE: 63 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed Sept 21 1916 ..... Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7th 1916, to Sept 21st 1916, that I last saw h[im] alive on Sept 21st 1916, and that death occured on the date stated above, at 11:A M.

The CAUSE OF DEATH* was as follows:
Myocarditis
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Cardio-Vascular Renal Disease
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H A Castle M. D.
Sept 21 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho — DATE OF BURIAL: Sept 23 1916

20. UNDERTAKER: Larkin & Sons Co — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. ....., ... St.)

Registration District No. 84

Primary Registration District No. 2161

File No. 10587

Registered No. 512

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Heberlein

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married

6. DATE OF BIRTH.

Not Known (Month) ..... (Day) 1 (Year)

7. AGE: about 60 years ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Fred Heberlein

(Address) American Falls Ida.

15. Filed Sept 27 1916

O. B. Steele
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...., that I last saw h..... alive on ..... 191...., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental - Struck by train

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Francis A Poole M. D.

9/25 1916 (Address) Owner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: American Falls Ida — DATE OF BURIAL: Sept 28 1916

20. UNDERTAKER: Larkin + Sons Co — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

[redacted] PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

15878

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

File No. 10

Registered No. 515

County of Bannock

City of Pocatello (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence B Hunter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Not Known (Month) 1 (Day) (Year)

7. AGE: about 65 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: William B Hunter

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. D. Johnson

(Address) Idaho Ida.

15. Filed Sep 30, 1916 O P Lucas Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22 1916, to Sept 26 1916, that I last saw him alive on Sept 26 1916, and that death occured on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows: Pneumonia

..... (Duration) ..... Yrs. 6 mos. 2 ds.

Contributory (Secondary) Exposure

..... (Duration ..... yrs. ..... mos. ..... ds.

9/30 1916 (Signed) A. Prescott M. D.

(Address) A. Prescott

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Afton Iowa — DATE OF BURIAL: Oct 2 1916

20. UNDERTAKER: Larkin & Sondo — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock Registration District No. 84

City of Pocatello Primary Registration District No. 3161

(No. ..... , ... St.)

File No. 15879

Registered No. 491

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William A. Rollins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Black

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Not Known (Month) (Day) 1884 (Year)

7. AGE: 32 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer): O.S.L.R.R.

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. W. A. Rollins

(Address) Pocatello

15. Filed Aug 13 1916 O. J. Steely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gunshot wound of Chest

Instantaneous Death

Homicidal

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Frances A. Poole M. D.

Aug 9 1916 (Address) Coroner Bannock Co

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dunyon Colo — DATE OF BURIAL: Aug 15 1916

20. UNDERTAKER: Larkin & Sondo — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

15880

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

File No. 10

Registered No. 492

County of Bannock

City of Pocatello (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clyde H. Zoller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 22 (Day) 1906 (Year)

7. AGE: 10 Yrs. 1 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: Henry J. Zoller

11. BIRTHPLACE OF FATHER (State or Country): Cincinnati Ohio

12. MAIDEN NAME OF MOTHER: Pearl Adshade

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Margaret Adshade
(Address) Pocatello, Idaho

15. Filed Aug 17, 1916 — O. B. Lewis, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Acute Consumption
.....
.....
.....(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pleurisy with Effusion
.....(Duration 3 yrs. ..... mos. ..... ds.
(Signed) O. B. Lewis M. D.
8-17 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello, Idaho — DATE OF BURIAL: Aug 17 1916

20. UNDERTAKER: Larkin & Sons — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PRNS. & SORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

15881

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 10
Registered No. 493

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. Ranch South of Pocatello St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Milton D Schroder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Exact date unknown / 8 / 94 / 1
(Month) (Day) (Year)

7. AGE: 22 Years ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): South Dakota

10. NAME OF FATHER: Fredrick Schroder

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gertrude Schroeder
(Address) Armour S. Dakota

15. Filed Aug 17, 1916 — O. E. Steele, Local Registrar

SYMS - YORK CO., PTG. & BDG. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Killed by lightning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frances H Poole M. D.
Aug 17 1916. (Address) Errors

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Armour S. Dakota — DATE OF BURIAL: Aug 23 1916

20. UNDERTAKER: Schumacher & Hall. — ADDRESS: Pocatello.

FORM V. S. No. 5-25 M. 1-16-13

15882

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 10

Registered No. 495

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2161

(No. 340 S. Fifth St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Gordon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. February 21st 1901 (Month) (Day) (Year)

7. AGE: 14 Yrs. 5 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Idaho

10. NAME OF FATHER: Peter Gordon Jr

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Lillian Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Gordon
(Address) Kemmerer Wyo.

15. Filed Aug 18 1916 O. B. Reed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-18-16 191..., to 8-18-16 191..., that I last saw him alive on 8-18-16 191..., and that death occured on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Uremic Convulsions

(Duration) ... Yrs. ... mos. 1 ds.

Contributory (Secondary) Acute Nephritis

(Duration) Prob'l yrs. ... mos. ... ds.

(Signed) F. P. Richards M. D.

8/18 1916 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kemmerer Wyo — DATE OF BURIAL: Aug 21 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 10 15883

Registered No. 498

Registration District No. 84

Primary Registration District No. 2161

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. Gen Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stanton Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June 17th 1899 (Month) (Day) (Year)

7. AGE: 17 Yrs. 2 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: John Brown

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Mary Edens

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Brown.

(Address) Maryland Idaho.

15. Filed Aug 23 1916 O P Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8/22/1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/20/1916, to 8/22/1916, that I last saw h[im] alive on 8/22/1916, and that death occured on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Septic Meningitis

(Duration) 1 Yrs. mos. 3 ds.

Contributory (Secondary) Ethmoidal & frontal sinusitis

(Duration yrs. mos. ds.

(Signed) Joseph Clothier M. D.

8-23-1916 (Address) P Pocatello, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Maryland Idaho — DATE OF BURIAL: Aug 24 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOKS. 24654

15884

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 10
Registered No. 499

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Hannah Weatherman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept. (Month) 18 (Day) 845 (Year)

7. AGE: 69 Yrs. 11 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Joseph Bridges

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Margaret Mace

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Simon P. Weatherman
(Address) Pocatello Idaho

15.
Filed Aug 25 1916
O. T. Howard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 24 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1916, to Aug. 24 1916, that I last saw her alive on Aug. 24 1916, and that death occured on the date stated above, at 8 34 P. M.

The CAUSE OF DEATH* was as follows:
Coronary Sclerosis
(Angina pectoris)
(Duration) ~ Yrs. One mos. ~ ds.
Contributory (Secondary) Hypostatic Pneumonia
(Duration ~ yrs. ~ mos. 6 ds.

(Signed) O. T. Howard M. D.
8/25 1916 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho — DATE OF BURIAL: Aug 27 1916

20. UNDERTAKER: Larkin & Sons — ADDRESS: Poc.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PRES. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1015885

Registered No. 500

1. PLACE OF DEATH.

County of Bannock

City of Inkom

(No. ....., ... St.)

Registration District No. 84

Primary Registration District No. 2161

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas C Hale

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Nov (Month) 10 (Day) 1849 (Year)

7. AGE: 66 Yrs. 9 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Steven Hale

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Mary E. Wright

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Inkom Pierce

(Address) Inkom Ida

15. Filed Aug 29 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on Killed by Cars Aug 25 1916, and that death occured on the date stated above, at 7057 M.

The CAUSE OF DEATH* was as follows:

Killed by Cars
Accident

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W F Howard M. D.

8 x 8 1916 (Address) Acting Coroner Oneida Co Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Giberton Colo	Sept 2 1916
20. UNDERTAKER	ADDRESS
Larkin & Sons Co	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

15886

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 9
Registered No. 486

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. Pocatello Gen. Hospital)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Fitzgerald

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed
6. DATE OF BIRTH: Exact date unknown 1848 (Month) (Day) (Year)
7. AGE: 68 Yrs. Mos. Ds. Near as known. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ireland
10. NAME OF FATHER: John Fitzgerald
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (State or Country): unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Martha Little
(Address) 340 North 16th Ave
15. Filed July 26th 1916
O B Freeze Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 22nd 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 191..., to July 22 1916, that I last saw h... alive on July 22 1916, and that death occured at the date stated above, at ... P. M.
The CAUSE OF DEATH was as follows:
Pulmonary Tuberculosis
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) R. Sp[illegible] M. D.
July 27 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: July 26 1916
20. UNDERTAKER: Schumacher & Harp — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15887

Registered No. 485

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2161

(No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward A Fuller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 16 (Day) 1880 (Year)

7. AGE: 36 Yrs. 3 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. L. Davis

(Address) Downey Idaho

15. Filed July 22 1916 O. J. Keen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1916, to July 19 1916, that I last saw h[illegible] alive on July 19 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver
Secondary Appendicitis Gall Bladder

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. L. Daniels M. D.

July 19 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: July 22 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

15888

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2nd Ward
File No. 9
Registered No. 483

1. PLACE OF DEATH.

County of Bannock
City of Pocatello
(No. 427 So 2nd St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benjaman N Rose

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. October (Month) 28 (Day) 1910 (Year)

7. AGE: 5 Yrs. 8 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer)... —

9. BIRTHPLACE (State or Country) Salt Lake City, Ut.

10. NAME OF FATHER Thomas Rose

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Sarah Neilson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas Rose
(Address) Pocatello Ida

15. Filed July 18 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1916, to July 17 1916, that I last saw him alive on July 17 1916, and that death occured on the date stated above, at 5½ P. M.

The CAUSE OF DEATH* was as follows:
Scarletina Anginosa

(Duration) — Yrs. — mos. 6 ds.

Contributory (Secondary)

(Duration — yrs. — mos. — ds.

(Signed) W. J. Howard M. D.
7/18 1916 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. DATE OF BURIAL: July 18 1916

20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - VORE CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

15889

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

File No. 9

County of .....

City of ..... (No. ....., ... St.)

Registered No. 482

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Mitchell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Married~~ Widowed

6. DATE OF BIRTH. Aug 14 1847 (Month) (Day) (Year)

7. AGE: 68 Yrs. 10 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Paxton Pa

10. NAME OF FATHER: William Cowan

11. BIRTHPLACE OF FATHER (State or Country): Paxton Pa

12. MAIDEN NAME OF MOTHER: Mary Brown

13. BIRTHPLACE OF MOTHER (State or Country): Paxton Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Pocatello Idaho

15. Filed July 11 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 10 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1916, to July 10 1916, that I last saw her alive on July 9 1916, and that death occured on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:

Inanition

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary) Carcinoma of Stomach

(Duration) 1 yrs. mos. ds.

(Signed) Frances N. Poole M. D.

July 10 1916 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida. DATE OF BURIAL: July 11 1916

20. UNDERTAKER: Lashley & Sons Co ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH.
Bureau of Vital Statistics

File No. 15890

Registered No. 481

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 216

(No. 360 South Fourth St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bertha M. Sandine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 1 (Day) 1887 (Year)

7. AGE: 29 Yrs. 3 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Marion A Dunbin

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Mattie James

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert D Sandine

(Address) Pocatello Idaho

15. Filed July 11, 1916 O F Steel Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1915, to June 10 1916, that I last saw h[illegible] alive on June 10 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pulmonary Tuberculosis

(Duration 3 yrs. ..... mos. ..... ds.

(Signed) Frances H Poole M. D.

July 11 1916 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: July 11 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

15891

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84

Primary Registration District No. 216

File No. 9

Registered No. 480

1. PLACE OF DEATH.

County of Bannock

City of Pocatello (No. East Center Street St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Orr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 12 (Day) 1909 (Year)

7. AGE: 7 Yrs. 1 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ogden

10. NAME OF FATHER Frank Curtis

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Helen

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl Landers

(Address) Pocatello

15. Filed July 7, 1916 — F. P. Reed, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 5th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental death run over abdomen by Automobile

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Francis A Poole M. D.

July 7 1916 (Address) Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: July 7 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMS - YORK CO., PTRS. & BDRS. 24954

FORM V. S. No. 5-25 M. 1-16-13

15892

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 216
File No. 19
Registered No. 489

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 434 East Wyeth St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ashley Marshall Lyon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 16 (Day) 1852 (Year)

7. AGE: 64 Yrs. 2 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER: Olin Lyon

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER: Matilda Hills

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Clara Lyon Peters
(Address) Watsonville Illinois

15. Filed July 28 1916 O B Reed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18, 1916, to July 25 1916, that I last saw him alive on July 25 1916, and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Castle M. D.
July 27 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: July 28 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

15893

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84

Primary Registration District No. 2161

File No. 10

Registered No. 490

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. Gen Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Sawlis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 20 (Month) (Day) 1891 (Year)

7. AGE: 25 Yrs. 4 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Holdridge Neb

10. NAME OF FATHER: John Sawlis

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Sarah Wilmot

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Sarah Chase
(Address) Nampa Ida.

15. Filed July 28 1916 J. H. Blevins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1916, to July 27 1916, that I last saw h.. alive on July 26 1916, and that death occured on the date stated above, at 10P M.

The CAUSE OF DEATH* was as follows:
Exhaustion

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Intestinal toxaemia

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) J. H. Blevins M. D.
7/25 1916 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: July 30 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 7017
File No. 15894
Registered No. .....

1. PLACE OF DEATH.
County of Teton
City of Victor
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Griffith

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. June (Month) 24 (Day) 1903 (Year)

7. AGE: 13 Yrs. 4 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Victor Idaho

10. NAME OF FATHER: Henry R. Griffith

11. BIRTHPLACE OF FATHER (State or Country): Willard Utah

12. MAIDEN NAME OF MOTHER: Sarah Stratton

13. BIRTHPLACE OF MOTHER (State or Country): Logan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. R. Griffith
(Address) .....

15. Filed 11-1-16 191.... Geo. D. Hall Local Registrar

SYMS - YORK CO., PTRS. & BRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1916, to Oct 30 1916, that I last saw him alive on Oct 30 1916, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Injury to Intestine followed by Internal Hemorrhage.

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Louis Vittrin M. D.
Oct 30 1916 (Address) Victor Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 13 yrs. 4 mos. 6 days. In the State 13 yrs. 4 mos. 6 days
Where was disease contracted if not at place of death? at Victor
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Victor Idaho — DATE OF BURIAL: Nov 1 1916

20. UNDERTAKER: L. Leppeth — ADDRESS: Victor Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 81

Primary Registration District No. 2158

File No. 15895

County of Bonner

City of Priest Lake (No. ..... St.)

Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tillman Franklin Greene

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 16 (Day) 1864 (Year)

7. AGE: 32 Yrs. 10 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boone Boone Co Iowa

10. NAME OF FATHER: Samuel Greene

11. BIRTHPLACE OF FATHER (State or Country): Boone Co Iowa

12. MAIDEN NAME OF MOTHER: Lotta Hoffman

13. BIRTHPLACE OF MOTHER (State or Country): Boone Co Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Green

(Address) Spokane

15.

Filed Nov 2 1916

Ed McCarthy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gun shot wound in neck severing it Carotid artery.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm M Ingalls Coroner D. By Patient.

11 2 1916 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: ..... 191...

20. UNDERTAKER: R L Bray ADDRESS: Sandpoint Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 116
Primary Registration District No. 2195
(No. ....., ... St.)

File No. 15896
Registered No. 44
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Tobias J Wedel

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: — (Month) — (Day) 1885 (Year)

7. AGE: 31 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Jacob P Wedel

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Anna Unruh.

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J P Wedel
(Address) Aberdeen Ida

15. Filed Oct 18 1916 Emma Timm
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1916, to Oct 17 1916
that I last saw h[im] alive on Oct 17 1916,
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Accidental injury to Hips & thighs

(Duration) ..... yrs. ..... mos. 6 hrs ..... ds.

Contributory (Secondary) Pulmonary embolism

(Duration) - yrs. - mos. - ds.

(Signed) Jno. C. Watkins M. D.
Oct 18 1916 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Aberdeen Ida
DATE OF BURIAL: Oct 20 1916

20. UNDERTAKER: O K Hays
ADDRESS: American Falls

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15897

1. PLACE OF DEATH.
County of Lincoln
City of Near Jerome
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maynard Thomas Marquess

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single
6. DATE OF BIRTH: July (Month) 9 (Day) 1912 (Year)
7. AGE: 4 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Lawrence E Marquess
11. BIRTHPLACE OF FATHER (State or Country): Mo
12. MAIDEN NAME OF MOTHER: Virgie Hallam
13. BIRTHPLACE OF MOTHER (State or Country): Arkansas
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Marquess
(Address) Jerome
15. Filed July 10 1916 C. D. Piper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 9 1916, to July 9 1916, that I last saw him alive on July 9 1916, and that death occurred on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) C. D. Piper M. D.
July 10 1916 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetery
DATE OF BURIAL: July 10 1916

20. UNDERTAKER: D. R. Harrison
ADDRESS: Jerome

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15898

Registered No.

1. PLACE OF DEATH.
County of Lincoln
City of Jerome
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 11

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Fred Lenard Harrington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: Sept 19 1847
(Month) (Day) (Year)

7. AGE: 69 yrs. 1 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Rancher
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass

10. NAME OF FATHER: Lenard Harrington

11. BIRTHPLACE OF FATHER (State or Country): Mass

12. MAIDEN NAME OF MOTHER: Emaline Gleason

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anna M Harrington
(Address) Jerome Ida

15.
Filed ..... 191...
E D Piper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 4 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8, 1916, to Nov 3 1916, that I last saw him alive on Nov 3 1916, and that death occurred on the date stated above, at 6:00a M.

The CAUSE OF DEATH* was as follows:
Mitral insufficiency
about
(Duration) 20 yrs. mos. ds.
Contributory (Secondary): nephritis
(Duration) yrs. mos. 20 ds.

(Signed) W. T. Schmershall M. D.
Nov 4 1916 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place ..... In the
of death ..... yrs ..... mos ..... ds. State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Jerome Cemetery — DATE OF BURIAL: Nov 5 1916

20. UNDERTAKER: D. A. Harrison — ADDRESS: Jerome Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 1017-2017
File No. 15899
Registered No. .....

1. PLACE OF DEATH.
County of Lincoln
City of Jerome (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME unnamed Karney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Oct (Month) 26 (Day) 1916 (Year)

7. AGE: .....Yrs. .....Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Jerom Idaho

10. NAME OF FATHER: Ora E Karney

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Eva Brunton

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. E. Karney
(Address) .....

15. Filed Nov 4 1916 E. D. Pyle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1916, to Nov 4 1916, that I last saw her alive on Nov 4 1916, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Inanition due to prematurity

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John A. Schmaltzhaus M. D.
19 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: ..... DATE OF BURIAL: .....191.....

20. UNDERTAKER: ..... ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

Form V. S. [illegible] 6-20-11.

[illegible]CATE OF DEATH

1. PLA[illegible] DEATH. Registration Di[illegible] 105

County of Idaho Primary Registration District No. 2183 File No. 19 15901

City of Weiser (No. [illegible], [illegible] St.) Registered No. [illegible]

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace Arp

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: March (Month) 18 (Day) 1833 (Year)

7. AGE: 83 yrs. 7 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: ~~Henry~~ [illegible] Paustian

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna Kruetzfeld

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hayman Bro.
(Address) Weiser Ida.

15.
Filed Oct 22 1916 H Moore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 21st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14th 1916, to October 21st 1916, that I last saw her alive on October 21st 1916, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial nephritis

(Duration) Indefinite yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Turner, M. D.
Oct 21 1916 (Address) Cottonwood, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: Oct 23 1916

20. UNDERTAKER: [illegible] Hayman — ADDRESS: Cottonwood Ida

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 27

Primary Registration District No. 2119

File No. 15902

Registered No. 37

1. PLACE OF DEATH.

County of Franklin

City of Preston

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wilma Barlow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 25 (Day) 1916 (Year)

7. AGE: ... Yrs. 2 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Preston Idaho

10. NAME OF FATHER Nathan Barlow

11. BIRTHPLACE OF FATHER (State or Country) Bountiful Utah

12. MAIDEN NAME OF MOTHER Dora M Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Woodruff Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nathan Barlow

(Address) Preston Idaho

15.

Filed Oct 24 1916 D. A. R. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1916, to Oct 23 1916, that I last saw her alive on Oct 23 1916, and that death occured on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Pylone stenosis —

Clinical diagnosis —

(Duration) — Yrs. 2 mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... ds.

(Signed) Gal States M. D.

Oct 24 1916 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston — DATE OF BURIAL: Oct. 25 1916

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15903
Registered No. 34

Registration District No. 27
Primary Registration District No. 2109
(No. ....., ... St.)

1. PLACE OF DEATH.
County of Franklin
City of Glendale
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Utahanna Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 21 (Day) 1916 (Year)

7. AGE: ....Yrs. 2 Mos. 7 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Glendale Idaho

10. NAME OF FATHER Orson Nelson

11. BIRTHPLACE OF FATHER (State or Country) Mink Creek

12. MAIDEN NAME OF MOTHER Sarah Keller

13. BIRTHPLACE OF MOTHER (State or Country) Mink creek

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Orson Nelson
(Address) Glendale

15. Filed 9/29 1916 Dan R Cutler Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1916, to Sept 28 1916, that I last saw h[illegible] alive on Sept 27 1916, and that death occured on the date stated above, at 11a M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) V Yrs. V mos. -2- ds.

Contributory (Secondary) V (Duration ..... yrs. ..... mos. ..... ds.

(Signed) G W Stales M. D.
Sept 29 1916 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mink Creek — DATE OF BURIAL: Sept 29 1916

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 15904
Registered No. 30

1. PLACE OF DEATH.
County of Franklin
City of Weston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lars Marion Rasmussen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
May (Month) 6 (Day) 1916 (Year)

7. AGE
..... Yrs. ..... Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Weston, Ida

10. NAME OF FATHER Martin Rasmussen.

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Elsie Fredrickson

13. BIRTHPLACE OF MOTHER (State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Martinus Rasmussen
(Address) Weston Ida.

15.
Filed 9-14 1916
R. A. Ruble
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1916, to May 26 1916, that I last saw him alive on May 26 1916, and that death occured on the date stated above, at 7.25 P M.

The CAUSE OF DEATH* was as follows:
Erysipelas
(Duration) ..... Yrs. ..... mos. 1½ ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) P. W. Lynch M. D.
5/31 1916 (Address) Franklin, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weston Ida
DATE OF BURIAL: 5/29 1916

20. UNDERTAKER
ADDRESS

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 15905
Registered No. 39

1. PLACE OF DEATH.
County of Franklin
City of Preston
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hazel Cranney

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Mar (Month) 20 (Day) 1894 (Year)

7. AGE: 22 Yrs. 7 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Had none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Logan Utah

10. NAME OF FATHER: H. K. Cranney

11. BIRTHPLACE OF FATHER (State or Country): Ohio U.S.A.

12. MAIDEN NAME OF MOTHER: Elizabeth White

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W Lohman
(Address) Preston Idaho.

15.
Filed Oct. 28 1916 D A Curtis Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1916, to Oct 27, 1916, that I last saw h[er] alive on Oct 27, 1916, and that death occured on the date stated above, at 7:45 P M.

The CAUSE OF DEATH* was as follows:
Acute peritonitis

(Duration) — Yrs. — mos. 7 ds.
Contributory (Secondary) Appendiceal abscess.
(Duration — yrs. 6 mos. — ds.

(Signed) Curtis Bland M. D.
10/28/1916 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Logan Utah — DATE OF BURIAL: Oct 29 1916

20. UNDERTAKER: W. C. Skidmore — ADDRESS: Preston Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15906

Registered No. 38

Registration District No. 21

Primary Registration District No. 2119

1. PLACE OF DEATH.

County of Franklin

City of Glencoe (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josephine Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 7 (Day) 1878 (Year)

7. AGE: 38 Yrs. 5 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: A. F. Bergquist

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Pernilla Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P. A. Bergquist Grace
(Address) Grace Idaho

15. Filed Oct 24 191.... D. A. Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20, 1916, to Oct 23, 1916, that I last saw h w alive on Oct 23, 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Unknown — patient died 6 hrs. after delivery of babe without ascertainable cause

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) /

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Laurie Bland M. D.

10/26, 1916 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Trunk Creek — DATE OF BURIAL: Oct 26 1916

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK MFG. CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 15907
Registered No. 25

1. PLACE OF DEATH.
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Lenea Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan. (Month) 31 (Day) 1908 (Year)

7. AGE: 8 Yrs. 9 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9. BIRTHPLACE (State or Country) Trout Creek Idaho

10. NAME OF FATHER J. H. Jensen

11. BIRTHPLACE OF FATHER (State or Country) Trout Creek Idaho

12. MAIDEN NAME OF MOTHER Amanda Sorenson Jensen

13. BIRTHPLACE OF MOTHER (State or Country) Manti Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. H. Jensen
(Address) Preston R. 7 D 1.

15. Filed Oct. 22 1916 D. A. Curtis Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That ~~I attended~~ deceased from ~~Feb 15~~ 1916 to ~~Oct 21~~ 1916, and ~~he died~~ I last saw ~~him~~ alive on ~~Oct 17~~ 1916, and that death occured on the date stated above, at 1 a. M.

~~No doctor in attendance~~

The CAUSE OF DEATH* was as follows: I examined this urine early in the Spring and know it was a bad case of diabetic infection -

(Duration) Yrs. 8 mos. [illegible] ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. R. Curtis Registrar M. D.
19..... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston Idaho	Oct. 22 1916
20. UNDERTAKER	**ADDRESS**
W. A. Goldsmith	Preston

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2109
File No. 15908
Registered No. 32

1. PLACE OF DEATH.
County of Franklin
City of Dayton.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mark Leeson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH.
Sept (Month) 10th (Day) 1858 (Year)

7. AGE
59 Yrs. ..... Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) England.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ann Eliza Willson
(Address) Dayton, Idaho.

15.
Filed Sept 23rd 1916 D. A. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept. (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1916, to Sept 22 1916, that I last saw h sm alive on Aug 18 1916, and that death occured on the date stated above, at 7.45 M.

The CAUSE OF DEATH* was as follows:
Endocarditis

(Duration) One Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. W. Lunch M. D.
19..... (Address) Weston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dayton Ida	9/25 1916
20. UNDERTAKER	ADDRESS
H. A. Skidmore	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.....
Primary Registration District No.....
(No. ....., ... St.)

File No. 15909
Registered No. 24

1. PLACE OF DEATH.
County of Franklin
City of Fairview
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eliza Newbury Rawlings

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. June (Month) ..... (Day) 1835 (Year)

7. AGE: 81 Yrs. 2 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewif
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: Newbury

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jane Stagg

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles Choules
(Address) Fairview

15.
Filed 9/9 1916 Dan Queen
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1916, to Sept 7 1916, that I last saw her alive on Sept 4 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. B. Cameron M. D.

19.... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairview
DATE OF BURIAL: Sept 9th 1916

20. UNDERTAKER: W. L. Skidmore
ADDRESS: Preston

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 88
Registered No. 1591

Registration District No. 27
Primary Registration District No. 2109
(No. ..... St.)

1. PLACE OF DEATH.
County of Franklin
City of Whitney
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Wilson Sprunt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 29 (Day) 1865 (Year)

7. AGE: 51 Yrs. 7 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: W. D. Sprunt

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Elizabeth Peacock

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jane L Warner
(Address) 110 West 30 St Ogden Utah

15.
Filed Sept 23 1916 D A Cullo
Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1916, to Sept 22 1916, that I last saw him alive on Sept 21 1916, and that death occured on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:
Gastric Ulcer

(Duration) 5 Yrs. — mos. — ds.

Contributory (Secondary)
(Duration — yrs. — mos. — ds.

(Signed) L C Canfield M. D.
9/22 1916 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Whitney — DATE OF BURIAL: Sept. 24 1916

20. UNDERTAKER: W A Fridmore — ADDRESS: Preston

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15911

Registered No. 29

1. PLACE OF DEATH.

County of Franklin

City of Ft Weston

Registration District No. 27

Primary Registration District No. 2119

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ellenes McDay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH. Sept. (Month) 18 (Day) 1852 (Year)

7. AGE 63 Yrs. 9 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER A. P. Jasperson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Ellenes Jasperson

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D W McDay
(Address) Weston Ida

15. Filed 9-14 1916 D. A. Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-10 1916, to 6-13 1916, that I last saw h. alive on 6-12 1916, and that death occured on the date stated above, at 6.30 A. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. W. Quick M. D.

19.... (Address) Weston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Ridgen Ut — DATE OF BURIAL .....191....

20. UNDERTAKER Lundquist — ADDRESS Logan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BKBS. 24655

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15912

Registered No. 36

1. PLACE OF DEATH.

County of Franklin

City of Preston (No. ....., ... St.)

Registration District No. 27

Primary Registration District No. 2119

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Cairncrough

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb. (Month) 24 (Day) 1852 (Year)

7. AGE: 64 Yrs. 7 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Thomas Cairncrough

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Minerva Cairncrough
(Address) Preston

15. Filed Oct 13 1916 Dora [illegible] Local Registrar

BYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1916, to Oct 12 1916, that I last saw him alive on Oct 12 1916, and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. W. Caufield M. D.

Oct 13 1916 (Address) Preston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairview Idaho — DATE OF BURIAL: Oct. 18 1916

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Filer

Registration District No. 38
Primary Registration District No. 2086
(No. ....., ... St.)

File No. 15913
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucinda Austin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Widow

6. DATE OF BIRTH. Aug (Month) 22 (Day) 1838 (Year)

7. AGE: 78 Yrs. 3 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Chester Butterfield

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Lois Steward

13. BIRTHPLACE OF MOTHER (State or Country): Vermond

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Nellie McClung
(Address) Filer Idaho

15. Filed 12-4 1916. A A Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1915, to Dec 4 1916, that I last saw h[illegible] alive on Dec. 4 1916, and that death occured on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) 1 0 Yrs. — mos. — ds.

Contributory (Secondary) Gastric ulcer

(Duration 2 yrs. — mos — ds.

(Signed) Frank A Dwight M. D.

Dec 4 1916 (Address) Filer Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Beloit Kas — DATE OF BURIAL: 1[illegible] 191[illegible]

20. UNDERTAKER: Eprake ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1086
Primary Registration District No. 1086
File No. 15914
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of Filer
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Fanny Wasel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married
6. DATE OF BIRTH. September 30 1892 (Month) (Day) (Year)
7. AGE: 24 Yrs. 1 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Cleveland Ohio
10. NAME OF FATHER Frank Vagner
11. BIRTHPLACE OF FATHER (State or Country) Bohemia
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (State or Country) Bohemia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Adolf Wasel
(Address) Filer Buhl Ida
15. Filed 11/28 1916 [illegible] Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 - 26 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1916, to Nov 26 1916, that I last saw her alive on Nov 26 1916, and that death occured on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
& Pneumonia
(Duration) - about two years Yrs. mos. ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A. E. McClusky M. D.
11/26 1916. (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Idaho — DATE OF BURIAL: 11-28 1916

20. UNDERTAKER: C. J. Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 2086
(No. ....., ... St.)

File No. 15915
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME True Stewart Bunce.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	W.	

6. DATE OF BIRTH: May (Month) 26 (Day) 1910 (Year)

7. AGE: 6 yrs. 6 mos. — ds.
IF LESS than 1 day how many ..... *hrs.* or ..... *mins.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER C. T. Bunce

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Elizabeth Houls

13. BIRTHPLACE OF MOTHER (State or Country) Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. T. Bunce
(Address) Filer.

15. Filed 11/17 1916 — O. A. Newberry, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 8 1916, to Nov. 16 1916, that I last saw him alive on Nov. 16 1916 and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 15 ds.

Contributory (Secondary) Measles.

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) O. A. Newberry M. D.
11/17 1916 (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Cemetery — DATE OF BURIAL: 11/17 1916

20. UNDERTAKER: H E Drake (Beer) — ADDRESS: Filer Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2086
(No. ..... St.)

File No. 15916
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henderson Eddy Stees

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
July (Month) 29 (Day) 1891 (Year)

7. AGE
25 Yrs. 3 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: J H Stees

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Abby C Sampson

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. H. Stees
(Address) Filer

15. Filed Nov 3 1916
Edward Coughlan
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
11 (Month) – 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-30 1916, to 11-2 1916, that I last saw h..... alive on 10-30 1916, and that death occured on the date stated above, at 11 a. M.

The CAUSE OF DEATH* was as follows:
Pulmonary T.B.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F Coughlan M. D.
11-3 1916 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Cemetery
DATE OF BURIAL: Nov 4 1916

20. UNDERTAKER: F E Drake.
ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15917

Registered No. 37

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Payette

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4

Primary Registration District No. 1008

(No. ....., ... St.)

2. FULL NAME L A Hanson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Feb (Month) 9 (Day) 1861 (Year)

7. AGE: 55 yrs. 9 mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a). Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: J. N. Hanson

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Susan Kissler

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Stephen Hanson
(Address) .....

15. Filed Nov 26 1916 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1916, to Nov 24 1916
that I last saw her alive on Nov 24 1916
and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Intestinal obstruction

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J C Woodward M. D.

11/24 1916 (Address) Payette, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverside Cemetery | DATE OF BURIAL: Nov 26 1916

20. UNDERTAKER: D. McClain | ADDRESS: Payette Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 15918
Registered No. 23

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME L. P. Deal

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. June (Month) 4 (Day) 1850 (Year)

7. AGE: 66 Yrs. 3 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Horseman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Anthony Deal

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary Gradzy

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George Deal
(Address) 605 Hamilton Spok. Wn.

15. Filed Oct-22 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9 A.M. Oct 21 1916, to 3:30 A.M. Oct 22 1916, that I last saw him alive on Oct 22 1916, and that death occured on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:
Shock followed by Strangulated Hernia
(Duration) 30 ~~Yrs.~~ Hours ~~mos.~~ ~~ds.~~

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Hunt Shephard M. D.
19..... (Address) Corner A & Alder Sts
Per Mrs. B. P. Heidal

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. | DATE OF BURIAL ..... 191...

20. UNDERTAKER: J. E. Heidal | ADDRESS C. D. A.

SYMS - YORK CO., PTRS. & SDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 15919
Registered No. 22

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bertha Embury

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 29 (Day) 1848 (Year)

7. AGE: 67 Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER P. Pederson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Agnes Embury
(Address) Coeur d'Alene

15. Filed Oct. 22 1916
J. Hughes
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 20th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1916, to Oct 20 1916, that I last saw her alive on Oct 10th 1916, and that death occured on the date stated above, at 8 9 M.

The CAUSE OF DEATH* was as follows:
Mitral valve disease of the heart

(Duration) 10 Yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jno Bunley M. D.
19 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Oct-22 1916

20. UNDERTAKER: J. C. Haskell — ADDRESS: C.D.A.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 715920

Registered No. 20

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D'Alene (No. .... St.)

Registration District No. 29

Primary Registration District No. 1050

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Delima Mayville

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) ..... (Day) 1873 (Year)

7. AGE: 43 Yrs. 6 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Onesime Ducharme

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Katherine Daindan

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph H. Mayville

(Address) 1163, 3rd St.

15. Filed Oct-25 1916 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 23rd 1916, to Oct. 24th 1916, that I last saw her alive on Oct. 24. 1:30 P.M. 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Puerperal eclampsia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Alexander Cairns M. D.

10/25/1916 (Address) 611 Garden Ave, C. d'A.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. Thomas Cemetery — DATE OF BURIAL: Oct. 26 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7 15921
Registered No. 24

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene

Registration District No. 29
Primary Registration District No. 1050
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Caroline Thompson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: March (Month) 11th (Day) 1846 (Year)

7. AGE: 72 yrs. 7 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife.
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: Edward Ericksson

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John A. Thompson
(Address) 908 Bancroft Ave. C d A

15.
Filed 10-27 1916
A. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 25th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 22nd 9 P.M. 1916, to Oct. 25th 1916
that I last saw her alive on Oct 25 1:30 P.M. 1916
and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:
Apoplexy.

..... (Duration) ..... yrs. ..... mos. 2 ½ ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Alexander Craven M. D.
Oct. 25th 1916 (Address) 611 Garden Ave.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....., ...yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Oct. 27 1916

20. UNDERTAKER: F. E. Kinkel — ADDRESS: C d A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 105
(No. ..... St.)

File No. 715922
Registered No. 21

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl F. Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 21 (Day) 1897 (Year)

7. AGE: 19 Yrs. 3 Mos. 2 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: Charles Carter

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Devonia Hall

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. F. Kroemer
(Address) 806 N. Third

15. Filed 10-26 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/11 1916, to 10/23 1916, that I last saw h[illegible] alive on 10/23 1916, and that death occured on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial nephritis.

(Duration) 4/ Yrs. ___ mos. ___ ds.

Contributory (Secondary)

(Duration ___ yrs. ___ mos. ___ ds.

(Signed) J. H. S. Thomas M. D.
10/23 1916 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montesano Wash
DATE OF BURIAL 191[illegible]

20. UNDERTAKER: Gus Nelson
ADDRESS Coeur D'Alene

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce
City of Lenore
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 92
Primary Registration District No. 2170
(No. ....., ... St.)

File No. 45923
Registered No. 12
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter Wilson Gilbert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
July - 24th 1866.
(Month) (Day) (Year)

7. AGE
50 yrs. 3 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer.
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Nevada.

10. NAME OF FATHER Joseph Gilbert

11. BIRTHPLACE OF FATHER (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Price.

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. W. Gilbert
(Address) Lenore. Idaho.

15.
Filed 11-15 1916 E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov - 14th 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13th 1916, to Nov 14th 1916, that I last saw him alive on Nov 14th 1916, and that death occurred on the date stated above, at 1:30 p M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart.

(Duration) - yrs. - mos. 4 ds.
Contributory (Secondary) Congestion
(Duration) - yrs. - mos. 10 ds.

(Signed) J. J. Livingston M. D.
11-15 1916 (Address) Cliff Idaho,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow Ida	11/16 1916

20. UNDERTAKER	ADDRESS
[illegible] Swan	[illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15924
Registered No. .....

1. PLACE OF DEATH.
County of Lemhi
City of .....
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Born 12 noon
October (Month) 2nd (Day) 1916 (Year)

7. AGE died at 8 a m 3rd
.....Yrs. .....Mos. .....ds.
IF LESS than 1 day how many 20 hrs. or .....min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Lemhi Co. Idaho

10. NAME OF FATHER George H Miller

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Flora Wells

13. BIRTHPLACE OF MOTHER (State or Country) Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ed Miller
(Address) Patterson, Idaho.

15.
Filed .....1916.. Saloma Cleveland
Local Registrar

SYMS - YORK CO., PYRS. & SOBS. 24658

MEDICAL CERTIFICATE OF DEATH

Infant

16. DATE OF DEATH
Oct (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2, 1916, to Oct 3 1916, that I last saw him alive on Oct 3 1916, and that death occured on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:
Malaya & Sahara.
Instrumental Interference
(Duration) .....Yrs. .....mos. 1 ds.
Contributory (Secondary) .....
(Duration) .....yrs. .....mos. .....ds.
(Signed) J. F. Gilmore M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: May Idaho — DATE OF BURIAL: Oct 3rd 1916

20. UNDERTAKER — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15925

Registered No. 32

1. PLACE OF DEATH.

County of Lemhi

City of Salmon

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41

Primary Registration District No. 2116

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Lucinda Horn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Sept 18th 1847 (Month) (Day) (Year)

7. AGE: 69 Yrs. 11 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. House Wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER John McCann

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. B. Horn

(Address) Salmon Idaho

15. Filed Sept 18 1916 Edith D Hendon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 17th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16" 1916, to Sept. 15 1916, that I last saw her alive on Sept. 15 1916, and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:

Chronic bronchitis, cirrhosis of liver (complications numerous & difficult to name diagnosis)

(Duration) 3 Yrs. — mos. — ds.

Contributory (Secondary) Myocarditis

(Duration — yrs. 3 mos. — ds.

(Signed) O Brayton M. D.

9/17 1916 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~ Salmon Cemetery DATE OF BURIAL 9-18 1916

20. UNDERTAKER W C Doebler ADDRESS Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15926
Registered No. 83

1. PLACE OF DEATH.
County of Lemhi
City of Northfork
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 3116

2. FULL NAME Samuel Hance Ireland Ballenger
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. June 21st (Month) 17 (Day) 1826 (Year)

7. AGE: 90 Yrs. 3 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Isaac Ballenger

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Margaret Leitch
(Address) Northfork Ida.

15. Filed Oct. 4, 1916 Edick Downing Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 3rd (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Old age

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W. L. Whitwell M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bail Creek — DATE OF BURIAL: Oct 4th 1916

20. UNDERTAKER: Henry Downing — ADDRESS: Northfork Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 41

Primary Registration District No. 2116

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15927

Registered No. 34

1. PLACE OF DEATH.

County of Lemhi

City of Tendoy

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Helen L Bird

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. August 13th (Month) (Day) 1850 (Year)

7. AGE: 66 Yrs. 1 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Fredrick Collins

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Nancy White

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Bird

(Address) Tendoy Idaho

15. Filed Oct 12 1916 Edith D Herndon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 11th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Hemiplegia

No Physician in attendance

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Doebler Coroner

10-11 1916 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 10-12 1916

20. UNDERTAKER: W. C. Doebler — ADDRESS: Salmon Idaho

BYMD - YORK CO. PTG. & BOOK. 24652

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15928
Registered No. 35

1. PLACE OF DEATH.
County of Lemhi
City of Salmon (No. ....., ... St.)

Registration District No. 41
Primary Registration District No. 2116

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Tormey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Do not Know (Month) (Day) 1 (Year)

7. AGE: about 75 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer): Miner

9. BIRTHPLACE (State or Country): Connecticut

10. NAME OF FATHER: Do not know

11. BIRTHPLACE OF FATHER (State or Country): Do " "

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. W. Shaw
(Address) Salmon

15.
Filed Oct 22, 1916 E. D. Hendon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 21st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20th 1916, to Oct 21st 1916
that I last saw him alive on Oct 21st 1916
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Fulminant Heart Trouble

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary): Old Age
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F. D. Wright M. D.
Oct 23 1916 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery
DATE OF BURIAL: 10-22" 1916.

20. UNDERTAKER: W. C. Doebler
ADDRESS: Salmon Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 401
Primary Registration District No. 2-116
(No. ..... St.)

File No. 15929
Registered No. 37
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Elizabeth Wolfe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. November 3rd 1882 (Month) (Day) (Year)
7. AGE: 33 Yrs. 11 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): Lemhi County Idaho
10. NAME OF FATHER: Henry Grieber
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Clara Nagle
13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Carl L Wolfe
(Address) Butte Montana
15. Filed Nov. 12 1916 E D Kreuder Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 20th 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1916, to Oct. 19 1916, that I last saw h[er] alive on Oct 19 1916, and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pericarditis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Laryngeal Syphilis
(Duration) do not know Yrs. ..... mos. ..... ds.
(Signed) Chas. F. Hammer M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 10-22" 1916.
20. UNDERTAKER: W C Doebler — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15930

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 41

Primary Registration District No. 2116

1. PLACE OF DEATH.

County of Latah

City of Palouse

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Elizabeth A Johnson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June 8th (Month) (Day) 1861 (Year)

7. AGE: 55 Yrs. 5 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER Holver Olesen

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Elsie Nelson

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. D. Johnson

(Address) Palouse Idaho.

15. Filed Nov. 12 1916 E D Hunter Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 8th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1915 to Nov. 8 1916, that I last saw h[er] alive on Nov. 8 1916, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Aortic regurgitation.

(Duration) about 2 years yrs. mos. ds.

Contributory (Secondary) Gastro duodenal

(Duration 16 yrs. mos. ds.

(Signed) Chas. F. Hannue M. D.

19..... (Address) Palouse

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse Cemetery

DATE OF BURIAL: Nov 10th 1916

20. UNDERTAKER: W C Taebler

ADDRESS: Palouse Ida

FORM V. S. No. [redacted] 16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 18
Primary Registration District No. 2182
File No. 15931
Registered No. 71

1. PLACE OF DEATH.
County of Bear Lake
City of Lanstan (No. ....., ... St.)

If death occurs away from usual residence, give name called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Irena Leamaster.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Female	White	Single (Write the word.)

6. DATE OF BIRTH. Nov (Month) 5 (Day) 1888. (Year)

7. AGE 28 Yrs. 10 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. At home.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Garfield Co. Utah.

10. NAME OF FATHER [redacted] William Leamaster.

11. BIRTHPLACE OF FATHER (State or Country) Sanpete Co. Utah.

12. MAIDEN NAME OF MOTHER Sarah Kearns.

13. BIRTHPLACE OF MOTHER (State or Country) Sanpete Co Utah

14. THE ABOVE IS [redacted] TO THE BEST OF MY KNOWLEDGE.
(Informant) [redacted] Leamaster
(Address) Keyburn Ida. Route 1.

15. Filed Nov. 10 191.. V. P. Killen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.., to ..... 191.., that I last saw h..... alive on ..... 191.., and that death occured on the date stated above, at 10:00 P.M.
The CAUSE OF DEATH* was as follows:

.....
.....
.....
.....(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary) .....
.....(Duration ....yrs. ....mos. ....ds.
(Signed) ..... M. D.
.....19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days In the State....yrs....mos....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Keyburn Ida. DATE OF BURIAL: Oct 2nd 1916

20. UNDERTAKER: [redacted] ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15932
Registered No.

1. PLACE OF DEATH.
County of Mundoka
City of Eden

Registration District No. 18
Primary Registration District No. 2102
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME James B Blaine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Don't Know

6. DATE OF BIRTH: Don't Know (Month) 1 (Day) (Year)

7. AGE: 73 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. A. Brickey
(Address) Hanson, Ida

15.
Filed Nov. 10 1916 V. P. Kilby Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1916, to Oct 15 1916
that I last saw h~~im~~ alive on Oct 14 1916
and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:
Peritonitis

..... (Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Mo Lamb M. D.
..... 19 ..... (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Snake river canyon near Hanson
DATE OF BURIAL: Oct 15 1916

20. ~~UNDERTAKER~~ ADDRESS
minister
T. H. Etheridge, Hanson Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15933

Registered No. 13

1. PLACE OF DEATH.
County of Minidoka
City of Hazelton

Registration District No. 18
Primary Registration District No. 2102
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary L. Hurd

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feby (Month) 18 (Day) 1911 (Year)

7. AGE: 5 yrs. 7 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Colo

10. NAME OF FATHER: Bert Hurd

11. BIRTHPLACE OF FATHER (State or Country): Nebr

12. MAIDEN NAME OF MOTHER: Emma Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe Butterworth
(Address) Hazelton

15.
Filed Nov. 10 1916 — V. P. Killen, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1916, to Oct 17 1916, that I last saw h[illegible] alive on Oct 17 1916 and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Cholera Infantun

..... (Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary): none
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno P Lamm M. D.
Oct 18 1916 (Address) Hazelton Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: Oct 21 1916

20. UNDERTAKER acted.
ADDRESS
Joe Butterworth — Hazelton.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

15934

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. ..... St.)

File No. 10
Registered No. 599

1. PLACE OF DEATH.
County of Bannock
City of .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James E. Mc. Dahl
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. July 3rd 1914 (Month) (Day) (Year)
7. AGE: Yrs. 3 Mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Mark Mc. Dahl
11. BIRTHPLACE OF FATHER (State or Country): Kansas
12. MAIDEN NAME OF MOTHER: Lola Conquest
13. BIRTHPLACE OF MOTHER (State or Country): Kansas
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. E. Howard
(Address) Pocatello Ida.
15. Filed Oct 22 1916 O B Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 21 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1916, to Oct 21 1916, that I last saw him alive on Oct 20 1916, and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Enteritis
(Duration) ..... Yrs. 2 mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) A. M. Newton M. D.
Oct 22/19 16. (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Oct 22 1916
20. UNDERTAKER: Schumacher & Hays — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

Dr Sprague

CERTIFICATE OF DEATH.

15935

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84

Primary Registration District No. 2161

File No. 10

Registered No. 5087

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 340 - So 6th Ave St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Florence Green

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child.

6. DATE OF BIRTH. ~~Sept~~ June 19 1916 (Month) (Day) (Year)

7. AGE ..... Yrs. 0 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Child

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Pocatello, Idaho

10. NAME OF FATHER Frank Green

11. BIRTHPLACE OF FATHER (State or Country) Montana

12. MAIDEN NAME OF MOTHER Kate Craig

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Green

(Address) 340 So 6th ave

15. Filed Sept 13 1916 O R Steely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 8 1916, to Sept. 13 1916, that I last saw h[er] alive on Sept. 13 1916 and that death occured on the date stated above, at 8 a M.

The CAUSE OF DEATH was as follows:

Otitis Media

.....

.....

.....

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Meningitis

(Duration ..... yrs. ..... mos. 3 ds.

(Signed) W. J. Hawes M. D.

9/13 1916 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cemetery — DATE OF BURIAL: Sept 14 1916

20. UNDERTAKER: Schumacher & Hall. — ADDRESS: Pocatello.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ROBS. 24854

FORM V. S. No. 5-25 M. 1-16-13

15936

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. ..... St.)

File No. 10
Registered No. 5055

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Roy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Feb. (Month) 28 (Day) 1916 (Year)

7. AGE: ..... Yrs. 6 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ogden Utah.

10. NAME OF FATHER James Roy.

11. BIRTHPLACE OF FATHER (State or Country) Wis.

12. MAIDEN NAME OF MOTHER Dora Lewis.

13. BIRTHPLACE OF MOTHER (State or Country) Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jane Roy.
(Address) Pocatello Ida.

15. Filed Sept 13, 1916 J. R. Steely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Pneumococcic Meningitis

(Duration) — Yrs. — mos. 8 ds.
Contributory (Secondary) Mastoid infection
(Duration) 1 Yrs. 2 mos. — ds.
(Signed) M. Lewis M. D.
9/13 1916 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida. DATE OF BURIAL: Sept 12 1916

20. UNDERTAKER: Larkin & Sons ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

15037

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 10

Registered No. 501

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

County of Bannock

City of Pocatello (No. 655 – North Garfield St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emil Wesley Larsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Child (Write the word.)

6. DATE OF BIRTH. March (Month) 17 (Day) 1916 (Year)

7. AGE Yrs. 5 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Child

(b) General nature of industry, business, or establishment in which employed (or employer)... —

9. BIRTHPLACE (State or Country) Pocatello Ida.

10. NAME OF FATHER Emil Larsen

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Pearl Lofthouse

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emil Larsen

(Address) Pocatello Ida.

15. Filed Sept 2 1916 J B Steele Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~Aug~~ Sept (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1916, to Sept 1 1916, that I last saw h~~im~~ alive on Sept 1 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Marasmus — Inanition

(Duration) Yrs. 2 mos. 14 ds.

Contributory (Secondary) Inherited Syphilis

(Duration Yrs. mos. ds.

(Signed) J B Steele M. D.

9-2-1916 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View Cem	Sept 3 1916
20. UNDERTAKER	**ADDRESS**
Schumacher & Hull	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

15939

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9

Registered No. 488

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. ..... St.)

Registration District No. 84

Primary Registration District No. 2161

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Mc Gullan.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Geo Mc Gullan

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Sylvia Smith

13. BIRTHPLACE OF MOTHER (State or Country): Brigham Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George McGullan

(Address) .....

15. Filed July 26 1916 O B Creer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26 1916, to July 26 1916, that I last saw him alive on July 26 1916, and that death occured on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth.

(Duration) few hours Yrs. ..... mos. ..... ds.

Contributory (Secondary) Foetal atelectasis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Newton M. D.

July 26 1916 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello — DATE OF BURIAL: July 26 1916

20. UNDERTAKER: Larkin & Sons — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

BYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. ..... St.)

File No. 95940
Registered No. 487

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock
City of Pocatello

2. FULL NAME Baby McGuillan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6. DATE OF BIRTH. July (Month) 26 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Pocatello

10. NAME OF FATHER Geo McGuillan

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Sylvia Smith

13. BIRTHPLACE OF MOTHER (State or Country) Brigham Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George McGuillan

(Address) .....

15. Filed July 26, 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26 1916, to July 26 1916, that I last saw h sm alive on July 26 1916, and that death occured on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... Yrs. few hours mos. ..... ds.

Contributory (Secondary) Foetal atelectasis

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ann. Newton M. D.

July 26 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pocatello — **DATE OF BURIAL** July 26 1916

20. UNDERTAKER Larkin & Sons Co — **ADDRESS** Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

15941

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 10

Registered No. 5114

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

(No. 726 E. Hayden St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Athinia Dagiantis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Greek

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Dec 20th (Month) (Day) 1915 (Year)

7. AGE: ....Yrs. 1 Mos. 9 ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Idaho

10. NAME OF FATHER: George Dagiantis

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Helen Buntis

13. BIRTHPLACE OF MOTHER (State or Country): Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Dagiantis

(Address) Pocatello Idaho

15. Filed Sept 25, 1916 O. B. Stevens Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 25 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....191...., to ....191....,
that I last saw h....alive on ....191....,
and that death occured on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:

Pneumonia

....(Duration) ....Yrs. ....mos. 5 ds.

Contributory (Secondary)

....(Duration) ....yrs. ....mos. ....ds.

(Signed) O. B. Stevens Local Reg. M. D.

9-25 1916 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Sept 26 1916

20. UNDERTAKER: Schumacher & Hay — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

15943

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 10
Registered No. 526

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 208 S. First in Place of St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Herbert Leroy Halvorsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. August 21 1914
(Month) (Day) (Year)

7. AGE: Yrs. 1 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... X
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ogden Utah

10. NAME OF FATHER Dagett Halvorsen

11. BIRTHPLACE OF FATHER (State or Country) Norwegian

12. MAIDEN NAME OF MOTHER Harriett Gray

13. BIRTHPLACE OF MOTHER (State or Country) Colorado.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. L. Reynolds
(Address) Pocatello, Idaho
10.14.1916

15.
Filed Oct 13 1916 O B Sears Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 14th
(Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Oct 13 1916
that I last saw him alive on Oct 13 1916
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Enteritis - gastritis
(Duration) Yrs. 1 mos. ds.
Contributory (Secondary) Colitis
(Duration yrs. mos. ds.
(Signed) O B Sears M. D.
(Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Oct 15 1916

20. UNDERTAKER: Schumacher & Hay — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 1015944
Registered No. 517

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 456 S. Grant St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew James Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug 24th 1916 (Month) (Day) (Year)

7. AGE: Yrs. 1 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George Thomas

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Cecelia Cibulka

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Cecelia Thomas
(Address) 456 So. Grant

15. Filed Oct 5th 1916 S B Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 3rd 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1916, to Oct 3 1916, that I last saw him alive on Oct 3 1916, and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J Mountain M. D.
10/4 1916 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Oct 5 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

15948

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 10

Registered No. 533

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 528 No Arthur St.)

Registration District No. 84

Primary Registration District No. 2161

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Dunkin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. October 31 (Month) (Day) 1916 (Year)

7. AGE: ....Yrs. ....Mos. ....ds.

IF LESS than 1 day how many I.O. hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: Edward A Dunkin

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Hattie May

13. BIRTHPLACE OF MOTHER (State or Country): Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward A Dunkin

(Address)

15. Filed Nov 1, 1916 O. J. Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1916 to Oct 31 1916 that I last saw him alive on Oct 31 1916 and that death occured on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

3 hrs (Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) ....(Duration ....yrs. ....mos. ....ds.

(Signed) J. M. Arment M. D.

11/4 1916 (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Nov 1 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

15949

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. #7 So Harrison St.)

File No. 10
Registered No. 534

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Francis Hassett Jr.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. October (Month) 30 (Day) 1916 (Year)

7. AGE: ....Yrs. 4 Mos. ....ds.
IF LESS than 1 day how many ....hrs. or 4 min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): Infant

9. BIRTHPLACE (State or Country): Pocatello, Ida.

10. NAME OF FATHER: James F. Hassett.

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Bessie Phalen.

13. BIRTHPLACE OF MOTHER (State or Country): Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. Hassett
(Address)

15. Filed Nov 2 1916 E. Nicholes
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-30 1916, to 11-2 1916, that I last saw him alive on 11-1 1916, and that death occured on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:
Uremic Convulsions

(Duration) Yrs. mos. 4 ds.
Contributory (Secondary) Premature birth

(Duration) yrs. mos. ds.
(Signed) C. W. Roberts M. D.
19.... (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: Nov 2 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

15950

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 10

Registered No. 519

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2161

(No. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella May Silvis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept 24 (Month) (Day) 1916 (Year)

7. AGE: ..... Yrs. 1 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Earl E. Silvas

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary Wright

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl E. Silvis

(Address) 145 No. Arthur.

15. Filed Oct 6, 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 6th (Month) (Day) 1916 (Year)

I HEREBY CERTIFY, That I attended deceased from Sept 24 1916, to Oct 6th 1916, that I last saw h alive on Oct 6th 1916 and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Enteritis,

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

1916 (Address) Pratten Building

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Oct 7 1916

20. UNDERTAKER: Schumacher & Hays — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

15953

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 10
Registered No. 235

1. PLACE OF DEATH.

County of Bannock
City of Pocatello
(No. 528 No Arthur St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hattie May Dunkin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. February 25 1897 (Month) (Day) (Year)

7. AGE: 19 Yrs. 8 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House wife
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country): Wyoming.

10. NAME OF FATHER: Geo E Boodry

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Mary Ostersen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward O. Dunkin
(Address)

15. Filed Nov 4 1916 O F Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November 3 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 1916, to Nov 3 1916, that I last saw her alive on Nov 3 1916, and that death occured on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) — Yrs. — mos. 5 ds.
Contributory (Secondary) Cardiac Insufficiency

(Duration ..... yrs. ..... mos. ..... ds.

11/4 1916 (Signed) J. Bennett M. D.
(Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lakeville Wyo — DATE OF BURIAL: Nov 5 1916

20. UNDERTAKER: Schumacher & Hay — ADDRESS: City

BYNS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

15954

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. ..... St.)

File No. 11
Registered No. 536

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lawrence J. Nelligan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Jan (Month) 1 (Day) 1889 (Year)

7. AGE
27 Yrs. 10 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. Automobile Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Park City Utah

10. NAME OF FATHER David P. Nelligan

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Sarah A. Harris

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs M. H. Griffin
(Address) 2661 - Adams Ave

15.
Filed Nov 4 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1916, to Nov 3 1916, that I last saw him alive on Nov 3 1916, and that death occured on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia base acute
.....(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. Beaumont M. D.
11/4 1916 (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: Nov 6 1916

20. UNDERTAKER: Larkin & Bond — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

6VMS - YORK CO., PTRS. & BOSS. 24654

15955

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 11
Registered No. 537

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nellie B. Lanch Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 14 (Day) 1893 (Year)

7. AGE: 23 Yrs. 11 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Joshua A. Nave

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Ida Leasure

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chester D. Smith
(Address) .....

15. Filed Nov 10, 1916 O. Hess Local Registrar

SYMS - YORK CO., PTRS. & BOXB. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9 1916, to Nov 9 1916, that I last saw her alive on Nov 9 1916, and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Eclampsia

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Edema Pulmonary-Sudden-Nephritis-probable.
(Duration ..... yrs. ..... mos. 1 day ds.

(Signed) J. M. Kerr M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Central City Mt. Greely Col.	Nov. 15 1916
20. UNDERTAKER	**ADDRESS**
Larkin & Sons Co	Pocatello

FORM V. S. No. 5-25 M. 1-16-13

15956

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 1
Registered No. 538

1. PLACE OF DEATH.
County of
City of
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo. Mathews, Mitchell.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. June (Month) 12 (Day) 1830 (Year)

7. AGE: 86 Yrs. 4 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Albans Vermont

10. NAME OF FATHER: Geo Mitchell

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dont Know.

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. Young
(Address) Pocatello Ida

15. Filed Nov 11, 1916 O. J. Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10 1916, to Nov 9 1916, that I last saw him alive on Nov. 9 1916, and that death occured on the date stated above, at 8a M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) — Yrs. — mos. 5 ds.

Contributory (Secondary) Valvular Heart disease

(Duration few yrs. — mos. — ds.

(Signed) W. J. Howard M. D.

11/11 1916 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 11/16 1916

20. UNDERTAKER: Larkin & Sons. | ADDRESS Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

15957

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8 F
Primary Registration District No. 2161
File No. 11
Registered No. 534

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. General Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME A Clark Gibson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 27 (Day) 1867 (Year)

7. AGE: 49 Yrs. 3 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: J. F. Gibson

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Clark

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edith A. Gibson
(Address) Pocatello Ida

15. Filed Nov 9 1916 — J. H. Stacy, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1916, to Nov 9 1916, that I last saw him alive on Nov 9 1916, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Myocarditis
(Duration) Yrs. mos. 10 ds.
Contributory (Secondary) Cholecystetis
Duration ? yrs. mos. ds.

(Signed) Frances A. Poole M. D.
11/9 1916 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: Nov 12 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-16-13

15958

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 11
Registered No. 540

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 734 N. Garfield St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frances Foley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct 9th (Month) (Day) 1908 (Year)

7. AGE: 7 Yrs. 1 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James Foley

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Jane Cooney

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Foley
(Address) 734 No Garfield

15. Filed Nov 12, 1916 — J. Steele — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 11th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23rd 1916, to Nov 11th 1916, that I last saw her alive on Nov 11th 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Scarlet Fever
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary): Peri Cardities & Lung Abscess
(Duration) ... yrs. ... mos. ... ds.

(Signed) H A Coates M. D.
Nov 11 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Nov 12 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

Dr. Howard

15959

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84

Primary Registration District No. 2161

File No. 11

Registered No. 541

1. PLACE OF DEATH.

County of Bannock

City of Pocatello (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Orson Heath

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 13 (Day) 1857 (Year)

7. AGE. 59 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer): Himself

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Henry Heath

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Martha M Bird

13. BIRTHPLACE OF MOTHER (State or Country): Boston

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E Hawks

(Address) Logan Utah.

15.

Filed Nov 20, 1916

W F Howard
Local Registrar

MEDICAL CERTIFICATE OF DEATH 10:15

16. DATE OF DEATH: Nov (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 30 1916, to Nov. 18 1916, that I last saw him alive on Nov. 8 1916, and that death occured on the date stated above, at 10:15 P.M.

The CAUSE OF DEATH* was as follows:

Hepatic Cirrhosis
(Ascites, mitral insufficiency, nephritis)

(Duration) few Yrs. ..... mos. ..... ds.

Contributory (Secondary): see above.

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W F Howard M. D.

11/20 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho — DATE OF BURIAL: Nov 26 1916

20. UNDERTAKER: Larkin & Sons Co — ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

15960

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 9161
(No. ..... , ... St.)

File No. 10
Registered No. 518

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Petree

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Married~~ Widowed

6. DATE OF BIRTH.
June (Month) 31 (Day) 1886 (Year)

7. AGE
30 Yrs. 1 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Sibley Ill.

10. NAME OF FATHER Chris Wolters

11. BIRTHPLACE OF FATHER
(State or Country) Germany

12. MAIDEN NAME OF MOTHER Mary Bartians

13. BIRTHPLACE OF MOTHER
(State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. E. A. Borchers
(Address) Gibson City Ill.

15.
Filed Oct 6th 1916
[illegible] Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1916, to Oct 4th 1916, that I last saw her alive on Oct. 4th 1916 and that death occured on the date stated above, at 10.45 P M.

The CAUSE OF DEATH* was as follows:
Traumatic Encephalitis
(Duration) Yrs. mos. 10 ds.
Contributory (Secondary) Crushing injury
(Duration) yrs. 1 mos. 1 ds.

(Signed) Wm. A. Wright M. D.
10/6 1916 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gibson City Ill. DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Larkin & Sons Co. ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-16-13

15961

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. ..... St.)

File No. 10
Registered No. 520

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Francis Diller

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: July (Month) 25 (Day) 1914 (Year)
7. AGE: 2 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: ...
(b) General nature of industry, business, or establishment in which employed (or employer): ...
9. BIRTHPLACE (State or Country): Arkansas
10. NAME OF FATHER: Albert Diller
11. BIRTHPLACE OF FATHER (State or Country): California
12. MAIDEN NAME OF MOTHER: Ora E. Morris
13. BIRTHPLACE OF MOTHER (State or Country): Ill
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. B. Morris
(Address) Pocatello
15. Filed Oct 8, 1916
O B Sisco
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 7 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 5 - 1916, to Oct 7, 1916, that I last saw h... alive on Oct 7, 1916, and that death occured on the date stated above, at 10 a M.
The CAUSE OF DEATH* was as follows:
Acute Nephritis
(Duration) — Yrs. 1 mos. 2 ds.
Contributory (Secondary)
(Duration — yrs. — mos. — ds.
(Signed) O B Sisco M. D.
10-8-1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida. | DATE OF BURIAL: Oct 8 1916
20. UNDERTAKER: Larkin & Sons | ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-16-13

15962

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 16
Registered No. 521

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Steed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb 1 1901 (Month) (Day) (Year)

7. AGE: 15 Yrs. 8 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas Steed

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Maud Miles

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J P Steed
(Address) Inkom Ida

15. Filed Oct 8 1916 O B [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 8 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1916, to Oct 9 1916, that I last saw her alive on Oct 4 1916 and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Inv or Phrmygeal
diphtheria
my complications
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) J F Miller M. D.
Oct 1916 (Address) Inkom Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Inkom Idaho — DATE OF BURIAL: Oct 10 1916

20. UNDERTAKER: Schumacher & Hay — ADDRESS: City.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24953

FORM V. S. No. 5-25 M. 1-16-13

15963

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 3161
File No. 10
Registered No. 533

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 605 N. Hayes St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Julia Vesely

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept 5th 1862
(Month) (Day) (Year)

7. AGE: 54 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria Europe

10. NAME OF FATHER: Frank Vodvarka

11. BIRTHPLACE OF FATHER (State or Country): Austria Europe

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. L. Vesely
(Address) 605 N. Hayes St

15. Filed Oct 10, 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 8th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1 1916, to Oct. 8 1916, that I last saw h alive on Oct 8 1916 and that death occured on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:
Pneumonia
Lues & Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. D.
Oct 10 1916 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Oct 10 1916

20. UNDERTAKER: Schumacher & Hug — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

15964

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock. Registration District No. 84
City of McCammon (No. ....., ... St.) Primary Registration District No. 2161
File No. 10
Registered No. 523

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Narcissa Huston McDill

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: October (Month) 3 (Day) 1835 (Year)

7. AGE: 81 yrs. 0 mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife.
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Madison, Indiana.

10. NAME OF FATHER: Samuel Fullenwider.

11. BIRTHPLACE OF FATHER (State or Country): Kentucky.

12. MAIDEN NAME OF MOTHER: Jane Logan Huston

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm J McDill
(Address) McCammon Ida

15.
Filed Oct 10, 1916 O B Swan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 9th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Sept 1st~~ 1916, to Oct 9th 1916 that I last saw her alive on Oct 9th 1916, and that death occurred on the date stated above, at 1:30 A M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) 5 yrs. mos. ds.

Contributory (Secondary) Senile debility

~~(Duration)~~ 10 yrs. mos. ds.

(Signed) ~~H~~ W. Brothers M. D.

Oct 9 1916 (Address) Malad, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston, Idaho — DATE OF BURIAL: Oct 13 1916

20. UNDERTAKER: Geo T Larkin & Son — ADDRESS: Pocatello, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & RULERS. BOISE 16872

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Dr Wood

15965

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 10

Registered No. 5234

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 545 South 5th Ave (St.)

Registration District No 84

Primary Registration District No 2161

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Finn H Berg.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.

February (Month) 14 (Day) 1881 (Year)

7. AGE

35 Yrs. 7 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Coal

(b) General nature of industry, business, or establishment in which employed (or employer)... Merchant.

9. BIRTHPLACE

(State or Country) Norway

10. NAME OF FATHER Halvor H Berg.

11. BIRTHPLACE OF FATHER

(State or Country) Norway.

12. MAIDEN NAME OF MOTHER Martha Finson.

13. BIRTHPLACE OF MOTHER

(State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O Tosdal A Berg

(Address) Springfield Idaho

15.

Filed Oct 13 1916 O P Stevens Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1916, to Oct 11 1916, that I last saw h[illegible] alive on Oct 11 1916, and that death occured on the date stated above, at 4.30 P M.

The CAUSE OF DEATH*, was as follows:

Valvular disease of the heart

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Acute rheumatic fever

(Duration 1 yrs mos. ds.

(Signed) Thomas H Poole M. D.

Oct 13 1916 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View Cemetery	Oct 13 1916
20. UNDERTAKER	ADDRESS
Schumacher & Hall	Pocatello Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STRS. 24958

15966

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 10-
Registered No. 525

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clare A. Edwards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
April (Month) 6 (Day) 1865 (Year)

7. AGE
51 Yrs. 6 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER James Edwards

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Katherine Petty

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S. O. Edwards
(Address) c/o Stalcup Pocatello

15.
Filed Oct 12 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Intestinal Acute
Entertan, Stomach
Poisoning.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
Oct 16 16 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sterling Utah — DATE OF BURIAL: Oct 13 1916

20. UNDERTAKER: Larkin & Sons — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

15967

Registration District No. 84
Primary Registration District No. 2161
(No. ..... , ... St.)

File No. 10
Registered No. 5217

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ella Woolsey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Aug (Month) 4 (Day) 1860 (Year)

7. AGE
56 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: James Naylor

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. W. F. Fiske
(Address)

15. Filed Oct 17, 1916
O. B. Lees
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1916, to Oct 16 1916, that I last saw h w alive on Oct 16 1916, and that death occured on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) ..... Yrs. ..... mos. 4 hrs. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) A. W. Newton M. D.
10-17-1916 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida — DATE OF BURIAL: Oct 18 1916
20. UNDERTAKER: Larkin & Sons Co. — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24854

15968

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2661
File No. 10
Registered No. 530

1. PLACE OF DEATH.
County of Bannock
City of Pocatello.
(No. 441 N. Wyoming St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gustavus Sahlberg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. December (Month) 10 (Day) 1861 (Year)

7. AGE: 55 Yrs. 10 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Contractor & Builder

9. BIRTHPLACE (State or Country) Gothenburg Sweden

10. NAME OF FATHER Gust. Sahlberg.

11. BIRTHPLACE OF FATHER (State or Country) Gothenburg Sweden

12. MAIDEN NAME OF MOTHER Christina.

13. BIRTHPLACE OF MOTHER (State or Country) Gothenburg Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Carl J. Sahlberg.
(Address) Pocatello Idaho.

15. Filed Oct 26, 1916 — O. J. Beach, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 25th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1916, to Oct 25 1916;
that I last saw him alive on Oct 24 1916;
and that death occured on the date stated above, at about 4 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculous peritonitis -
(Duration) 2 or 3 Yrs. mos. ds.
Contributory (Secondary) Arteria Sclerosis - and inability to eat and assimilate food
(Duration yrs. mos. ds.

(Signed) J. McKay M. D.
Oct 25 1916 (Address) Pocatello Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Oct 27 1916

20. UNDERTAKER: Schumacher & Hart — ADDRESS: Pocatello Idaho

SYMS - YORK CO., PTRS. & STRS. 24656

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl, (No. ....., ... St.)

Registration District No. 39
Primary Registration District No. 2087

File No. 15969
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Elane Griffin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June 30 1914 (Month) (Day) (Year)

7. AGE: 2 yrs. 4 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry business or establishment in which employed (or employer): ✓

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William H. Griffin

11. BIRTHPLACE OF FATHER (State or Country): Grant Co. Lancaster, Wisconsin

12. MAIDEN NAME OF MOTHER: Grace Hanna Griffin

13. BIRTHPLACE OF MOTHER (State or Country): Bevan Wales - Grace Hanna Griffin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Griffin
(Address) .....

15.
Filed 11-27 1916 J. Thornley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November 26 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1916, to Nov 26 1916 that I last saw h er alive on Nov 26 1916 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. 12 ds.

Contributory (Secondary) Peritonitis

..... (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) A. T. Mullaney M. D.

11-26 1916 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery
DATE OF BURIAL: Nov. 28 1916

20. UNDERTAKER: J E Schmidt
ADDRESS: Buhl

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 15970
Registered No. ____

1. PLACE OF DEATH.
County of Twin Falls
City of Burke
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lillian Ralston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb 2 1902 (Month) (Day) (Year)

7. AGE: 14 Yrs. 9 Mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Colorado

10. NAME OF FATHER J. H. Ralston

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Lenora Fisk

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. H. Ralston
(Address) Wendell - Idaho

15. Filed Nov. 3 1916 J. H. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 191__, to ____ 191__, that I last saw h__ alive on ____ 191__, and that death occured on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:
died suddenly. Said to have had a chronic kidney lesion.

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____
(Duration ____ yrs. ____ mos. ____ ds.

(Signed) Chas. Wetherbee M. D.
11-2 1916 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Burke — DATE OF BURIAL: 11/3 1916

20. UNDERTAKER: H. B. Evans — ADDRESS: Burke

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24858

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15971

1. PLACE OF DEATH. Registration District No. 6
County of Gem Primary Registration District No. 6
City of Emmett (No. ..., ... St.) Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Marvin Dodds

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: not known ..... 1 (Month) (Day) (Year)
7. AGE: 28 yrs. about mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): England
10. NAME OF FATHER: not known
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: not known
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B O Clark
(Address) Emmett Ida
15.
Filed 11/30 1916 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 28 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr 16 1916, to Nov 28 1916, that I last saw h alive on Nov 27 1916, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Ex fecal colitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Injury from Gun Explosion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B O Clark M. D.

19..... (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 11/29 1916
20. UNDERTAKER: C D Breckenridge — ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

FORM V. S. No. 5-25 M. 1-16-17

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15972

Registered No. .....

1. PLACE OF DEATH
County of Emmett
City of Emmett
(No. ..... St.)
Registration District No. .....
Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rev. Richard Barrett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June 27 (Month) (Day) 1834 (Year)

7. AGE 82 Yrs. 4 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Minister
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Wm Barrett

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Grace Glanville

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James H. Barrett.
(Address) .....

15.
Filed J. L. Reynolds 11/22/16
Local Registrar

SVMS - YORK CO., PTRS. & BOBS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Nov 20 1916,
that I last saw him alive on Nov 20 1916,
and that death occured on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows:
Grip
.....
.....
.....
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Age, palsy, Nephritis
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) K. C. Cummings M. D.
11/22 1916 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 11/22 1916

20. UNDERTAKER: O. D. Buckman
ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15973
Registered No. .....

1. PLACE OF DEATH.
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

2. FULL NAME Alexander S. Womack

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower

6. DATE OF BIRTH.
Mar. (Month) 26 (Day) 1836 (Year)

7. AGE
80 Yrs. 7 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Not Known

10. NAME OF FATHER Green Womack

11. BIRTHPLACE OF FATHER
(State or Country) Not Known

12. MAIDEN NAME OF MOTHER Agnes Cunningham

13. BIRTHPLACE OF MOTHER
(State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Womack
(Address) Emmett Idaho

15.
Filed 11/24 1916
J. L. Reynolds
Local Registrar

BYNS – YORK CO. PTRS. & ROBS. 24954

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

.....
.....
.....
.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) .....
.....(Duration .....yrs.....mos.....ds.
(Signed).....M. D.
.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 11/21 1916
20. UNDERTAKER: C. R. Buckman
ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15974

Registered No. .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH.

Registration District No. 4

Primary Registration District No. .....

County of Gem

City of Emmett (No. 1 Rd St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Son of Rolla J. Crill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Nov (Month) 8 (Day) 1916 (Year)

7. AGE: ..... Yrs. ..... Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Rolla J. Crill

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Jessie P. Hunt

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R J Crill

(Address) Emmett Ida

15.

Filed Nov 11 1916

J. H. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1916, to Nov 10 1916, that I last saw h[illegible] alive on Nov 10 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....

.....

.....(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Reynolds M. D.

11/10 1916 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho

DATE OF BURIAL: 11/11 1916

20. UNDERTAKER: C O Buckmun

ADDRESS: Emmett

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15975

Registered No. .....

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

County of Bennock

City of Pocatello

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Nelson Ford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Baby

6. DATE OF BIRTH. July (Month) 9 (Day) 1916 (Year)

7. AGE: ....Yrs. 3 Mos. 28 ds.* IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Coeur d'Alene Reservation

10. NAME OF FATHER: Peter N. Ford

11. BIRTHPLACE OF FATHER (State or Country): Coeur D. Alene Res.

12. MAIDEN NAME OF MOTHER: Mary Smith

13. BIRTHPLACE OF MOTHER (State or Country): Coeur D'Alene Res.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Ford

(Address) Desmet, Ida.

15.

Filed Nov 7 1916. John Post Deputy Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1916, to Nov 1916, that I last saw h.s.n. alive on Nov 6 1916, and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(Duration) Four months ds.

Contributory (Secondary) Anaemia and Malnutrition

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Eugene M. Hall M. D.

19..... (Address) Desmet. Ida. Nov 7 16

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida. DATE OF BURIAL: Nov 9 1916

20. UNDERTAKER: John Post ADDRESS: Desmet, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2049
File No. 15976
Registered No. .....

1. PLACE OF DEATH.
County of Benewah
City of St Maries
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Farrell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Nov (Month) ..... (Day) 1856 (Year)
7. AGE: 60 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Vermont
10. NAME OF FATHER: James Farrell
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Mary Noland
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Farrell
(Address) St Maries
15. Filed Nov 9 1916 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 7 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 20, 1916, to Oct 20 1916, that I last saw him alive on Oct. 20 1916, and that death occured on the date stated above, at 5a M.
The CAUSE OF DEATH* was as follows:
Endocarditis & heart insufficiency
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Owen D Pearl M. D.
Oct 9 1916 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Everett. Wash. DATE OF BURIAL: Nov. 10 1916
20. UNDERTAKER: H E Hunt. ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15977

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Benewah

City of St Maries

(No. ....., ... St.)

Registration District No. 92

Primary Registration District No. 2049

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Olson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 96 Yrs. — Mos. — ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): D K.

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Nov. 18 1916. H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....191....., to .....191.....,

that I last saw h.....alive on .....191.....,

and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Internal Abdominal injury, hemorrhage, rupture of Stomach + bladder, Result from injury to left side etc.

(Duration) Yrs. 4 hours mos. 1 ds.

Contributory (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) J. Winebrenner, Co. M. D.

11/18 1916 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Nov 20 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St M.

EVANS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15978

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Benewah

City of Cor Cassp.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32

Primary Registration District No. 2049

(No. ..... St.)

2. FULL NAME Sam Rovich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan. (Month) ..... (Day) 1895 (Year)

7. AGE: 21 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Nikola Rovich

11. BIRTHPLACE OF FATHER (State or Country): Austria Dorvoid

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Nov 17 1916 H Eckhart Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Injury of ~~left~~ right side of head by falling tree, shock & hemorrhage

(Duration) Yrs. 45 Minutes mos. ..... ds.

Contributory (Secondary) None

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C J Kinsolving Coroner M. D.

11/17 1916 (Address) St Maries Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: Nov 19 1916

20. UNDERTAKER: H Eckhart — ADDRESS: St Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15979

Registered No. .....

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bennewah

City of St Maries

2. FULL NAME Robert Forbs Winslow Briggs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH. May (Month) 24 (Day) 1875 (Year)

7. AGE 41 Yrs. ..... Mos. 5 ds. 29

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work... Dentist

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Gardner Grundy Co. Ill.

10. NAME OF FATHER E.D. Briggs

11. BIRTHPLACE OF FATHER (State or Country) Dr 11

12. MAIDEN NAME OF MOTHER Emma Winslow

13. BIRTHPLACE OF MOTHER (State or Country) D 11.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ida Paul Briggs

(Address) St Maries Ida.

15. Filed Nov 22 1916 H E Hmsh Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1916, to Nov 21 1916, that I last saw h im alive on Nov 21 1916, and that death occured on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder

(Duration) ..... Yrs. 10 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H Blommett M. D.

11/22 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL St Maries | **DATE OF BURIAL** Nov 22 1916

20. UNDERTAKER H E Hmsh | **ADDRESS** St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SNRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15980

Registered No. .....

1. PLACE OF DEATH.

County of Benewah

City of St Maries

Registration District No. 82

Primary Registration District No. 2049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Beldon M Delany

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 19 (Day) 1879 (Year)

7. AGE: 37 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Lab.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: David Delany

11. BIRTHPLACE OF FATHER (State or Country): Ten.

12. MAIDEN NAME OF MOTHER: Jane Edgar

13. BIRTHPLACE OF MOTHER (State or Country): Vrs.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R J Farrell

(Address) Chatcolet

15. Filed Nov 22 1916 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 22 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17 1916, to Nov 22 1916, that I last saw h alive on Nov 22 1916, and that death occured on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D E Cromwell M. D.

11/22 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Coeur d Alene — DATE OF BURIAL: 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15981

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Benewah

City of St Maries

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 22

Primary Registration District No. 2049

(No. ....., ... St.)

2. FULL NAME Chokee Migamoto

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1883 (Year)

7. AGE: 23 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER: D. K.

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D E Cornwell

(Address) St Maries

15.

Filed 11-26 1916

H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1916, to Nov 26 1916, that I last saw h[illegible] alive on Nov 26 1916 and that death occured on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:

Tuberculos pentonitis

(Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D E Cornwell M. D.

11/26/16 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 11-28 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & BDRS. 24853

2057 15982

City of St Maries (No. ....., ... St.) Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruby Marshall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 20 (Day) 1902 (Year)

7. AGE: 14 Yrs. / Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School Girl
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. W. Marshall

11. BIRTHPLACE OF FATHER (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Mary A Broushear

13. BIRTHPLACE OF MOTHER (State or Country) Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J W Marshall
(Address) St Maries

15. Filed Nov 29 1916 H E Hunt Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24th 1916, to Nov 28 1916, that I last saw her alive on Nov 26 1916, and that death occured on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
and Laryngitis

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Owen D Hart M. D.

Nov 29 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 11/29 1916

20. UNDERTAKER: H E Hunt — ADDRESS: S M.

Form V. S. No. 5 2M 1-15-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH — Registration District No. 65

County of Kootenai — Primary Registration District No. 2145

City of Princeton (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Mendenhall

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Married

6. DATE OF BIRTH — March 18 (Month) (Day) 1873. (Year)

7. AGE — 43 yrs. 8 mos. 25 ds. — IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Laborer -

9. BIRTHPLACE (State or Country) Minnesota

10. NAME OF FATHER Isaac Mendenhall

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Katherine Earl

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Josie Trotter
(Address) Potlatch R. F. D

15.

Filed Nov. 14 1916 — Dr. J. W. Thompson, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH — November 13" 1916. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1916, to Nov 13" 1916, that I last saw him alive on Nov 10" 1916, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Fracture of Spinal Column (Accidental) by fall of tree -

(Duration) yrs. 5 mos. 24 ds.

Contributory (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) W. W. Cornell M. D.

Nov 14 1916 (Address) Princeton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL — Mendenhall Cem't | Nov 13 1916

20. UNDERTAKER — E Anderson | ADDRESS — Palouse Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK. THIS IS A PERMANENT RECORD

B—Every question on this certificate must be answered either with the word or figure to express the fact, or the word NONE where that is the correct answer. If the exact date of any event cannot be stated, the best possible approximation should be given. AGE should be carefully calculated in years and months, and if less than one year in days. If unknown, it may be stated as PRACTICALLY ..... If born dead, or if death occurred before birth, so state. Do not use abbreviations or ditto marks. Make no erasures. Consult the physician, undertaker, and other persons having knowledge of the facts before writing.

PHYSICIAN'S OR MIDWIFE'S CERTIFICATE OF STILLBIRTH

I hereby certify that I attended the stillborn child of ..... who was born alive at ..... M. on the ..... day of ..... 19..... that I last visited the mother on the ..... day of ..... 19..... and that the child was not living when I last saw it, but was born dead on the ..... day of ..... 19..... The CAUSE OF DEATH was as follows:

.....

(Signed) ..... M. D.

19..... (Address) .....

Form - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65
Primary Registration District No. 2145
(No. , St.)

File No. 15985
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Zelda A Roach

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Oct (Month) 25 (Day) 1916 (Year)

7. AGE: yrs. mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Walter Roach

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Pearl Hyll

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Roach
(Address) Pattaley Idaho

15. Filed Nov. 14 - 1916. J. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 11 (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-13 1916, to 11-13 1916, that I last saw her alive on 11-13 1916, and that death occurred on the date stated above, at 5P M.

The CAUSE OF DEATH* was as follows:
Lagrippe

(Duration) yrs. mos. 1 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J S Ward M. D.
11/14/1916 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rock Creek — DATE OF BURIAL: Nov 15 1916

20. UNDERTAKER: E Anderson — ADDRESS: Palouse

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 65

County of Latah

Primary Registration District No. 2145

File No. 15986

City of Okaway Ida. (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annie Ackerman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH

October 2 1884
(Month) (Day) (Year)

7. AGE

32 yrs. 2 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... House wife

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE

(State or Country) Latah Co. Ida

10. NAME OF FATHER William Bircher

11. BIRTHPLACE OF FATHER

(State or Country) Taylor Co W Virginia

12. MAIDEN NAME OF MOTHER Lydia E Fletcher

13. BIRTHPLACE OF MOTHER

(State or Country) Bath Co Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Ackerman

(Address) Potlatch Ida.

15.

Filed Dec. 7th 1916 D. J.W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 6th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 2nd 1916, to Dec 6 1916, that I last saw her alive on Dec. 6 1916, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pneumonia.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Erysipelas. (facial)

..... (Duration) ..... yrs. ..... mos. 4 ds.

(Signed) J.W. Thompson M. D.

Dec. 7 1916 (Address) Potlatch Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fuen Cemetery	Dec 1916

20. UNDERTAKER	ADDRESS
E. Anderson	Pullman. Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

15988

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 19
Registered No. 13

1. PLACE OF DEATH.
County of Gem
City of Emmett

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Essie Broadway Henry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 3 (Day) 1865 (Year)

7. AGE: 49 Yrs. 2 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): House wife

9. BIRTHPLACE (State or Country): West Coms

10. NAME OF FATHER: Philip Leavitt

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Lizzie Leavitt

13. BIRTHPLACE OF MOTHER (State or Country): Can not say

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles Henry
(Address) Emmett Idaho

15.
Filed Nov 24 1916 E Yadney
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 24th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 18th 1916, to Nov. 24th 1916, that I last saw her alive on Nov 24th 1916, and that death occured on the date stated above, at 10:15 P.M.

The CAUSE OF DEATH* was as follows:

Croupous Pneumonia

(Duration) ..... Yrs. ..... mos. 6 to 10 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Alfred L Skippen M. D.
19..... (Address) Sweet Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: Nov 26 1916

20. UNDERTAKER: Charles W Henry — ADDRESS: Emmett Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 97

Primary Registration District No. 2174.

File No. 15989

County of Nezperce

City of Nezperce (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Augusta E. Corbins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Widow

6. DATE OF BIRTH: Nov (Month) 30 (Day) 1848 (Year)

7. AGE: 67 yrs. 11 mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Brown

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Moyer

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): A. E. Corbins
(Address): Lapwai, Idaho.

15.
Filed Nov. 16 1916 — Nezperce Idaho. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June. 1915., to Nov. 1916 and that I last saw h-- alive on Nov 15 1916 and that death occurred on the date stated above, at 5 p. M.

The CAUSE OF DEATH* was as follows:

Uremic Comma.

12 hours.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Ch. Interstit Nephritis.

(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) Thos M Talley M. D.

19 ..... (Address) Lewiston Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Nov 18 1916

20. UNDERTAKER: L. B. Mann. — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

15992

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 116
Primary Registration District No. 2151c
(No. ....., ... St.)
File No. 1
Registered No. 47
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Esther Luella Hoffner

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Feb 7 (Month) (Day) 1908 (Year)

7. AGE: 8 yrs. 9 mos. 18 ds.
IF LESS than 1 day how many .....*hrs. or* .....*mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Dakota

10. NAME OF FATHER: Christian C. Hoffner

11. BIRTHPLACE OF FATHER (State or Country): South Dakota

12. MAIDEN NAME OF MOTHER: Fredrika Sanden

13. BIRTHPLACE OF MOTHER (State or Country): South Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Christian C Hoffner
(Address) Aberdeen Ida

15.
Filed Nov 25 1916 Mcmenamin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 25 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,
that I last saw h.....alive on ....., 191...,
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Rifle-bullet wound of brain. Accident.
Died instantly

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) No physician in attendance

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Cameron M. D.
Nov 25 1916 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: German Lutheran Cemetery Aberdeen Ida
DATE OF BURIAL: Nov 30 1916

20. UNDERTAKER: Latimy & C. C. Hoffner
ADDRESS: Aberdeen Ida

SYMS - YORK CO., PTRS. & BORS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. 2192

File No. 15993

Registered No. 89

County of Bingham

City of Thomas Precinct (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lyle James Sorensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (X) Nov. (Month) 7th (Day) 1916 (Year)

7. AGE: ....Yrs. ....Mos. 1 ds. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Thomas Precinct Bingham Co Idaho

10. NAME OF FATHER: William G. Sorensen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Florence Webb James

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William G Sorensen
(Address) Blackfoot Idaho R.F.D. # 2

15. Filed Nov 8 1916 M. E. Parkin Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 7th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 6th 1916, to Nov 7th 1916, that I last saw him alive on Nov. 6 1916, and that death occured on the date stated above, at 5-15 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 1 Yrs. ... mos. ... ds.

Contributory (Secondary) Placenta Previa

(Duration) ... Yrs. ... mos. ... ds.

(Signed) M. E. Parkin M. D.

Nov 8 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Thomas-Pentrods Cem — DATE OF BURIAL: Nov. 8 1916

20. UNDERTAKER: William G Sorensen — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

(82)

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ....., ... St.)

File No. 15994
Registered No. 96

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James A. Crystal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 1 (Day) 1853 (Year)

7. AGE: 62 Yrs. 11 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): Miner until 1911 (Mineral mining)

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Andrew Crystal

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Betsie Cousins

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs James A Crystal
(Address) Blackfoot, Del R 3 Box 72

15.
Filed Nov 12 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1916, to Nov 10 1916, that I last saw him alive on Oct 10 1916, and that death occured on the date stated above, at 8:20 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(Duration) — Yrs. — mos. 15 ds.

Contributory (Secondary) Chronic Bronchopneumonia and arterio sclerosis

(Duration 15 yrs. ..... mos. ..... ds.

(Signed) W W Peck M. D.

11/12 1916 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: American Falls Idah | DATE OF BURIAL ..... 191...

20. UNDERTAKER: E J Funk | ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

(83)

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2124

Primary Registration District No. 2124

File No. 15995

Registered No. 91

(No. Blackfoot R.F.D. 3 St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot R F D 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob G. Toney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Aug (Month) 15 (Day) 1840 (Year)

7. AGE: 76 Yrs. 2 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emmett J. Toney
(Address) Blackfoot Ida

15. Filed Nov 13 1916. M. E. Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1915, to Nov 11 1916, that I last saw him alive on Nov 11 1916, and that death occured on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(Duration) 2 Yrs. — mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) B. Davis M. D.

(Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elk City Kansas — DATE OF BURIAL ..... 191...

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15996

Registered No. 93

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 1107

(No. ..... West Bridge St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elsie Narcissa Carr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct. (Month) 13 (Day) 1910 (Year)

7. AGE 6 Yrs. 1 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Huntsville Wash

10. NAME OF FATHER Chas. E. Carr

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Lydia Hammer

13. BIRTHPLACE OF MOTHER (State or Country) Huntsville Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lydia Carr

(Address) Huntsville, Wash.

15.

Filed Nov 15 1916

W. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1916, to Nov 15 1916, that I last saw her alive on Nov 15 1916, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary) Rheumatism

(Duration yrs. 4 mos. ds.

(Signed) F. A. Mitchell M. D.

11/15 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Huntsville Washington | DATE OF BURIAL 191

20. UNDERTAKER E J Peck | ADDRESS Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24652

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2141
File No. 15997
Registered No. 93

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information. Corrected Record

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Scott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. April (Month) 6 (Day) 1847 (Year)

7. AGE: 69 Yrs. 7 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: James Meek

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Mary Wright

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lida Worden
(Address) Grand Forks B. C.

15. Filed Nov 20 1916 M. E. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1916, to Nov 18 1916, that I last saw her alive on Nov 16 1916, and that death occured on the date stated above, at 8:45 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 10 Yrs. ..... mos. ..... ds.

Contributory (Secondary) —

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Beck M. D.

11/19 1916 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Idaho
DATE OF BURIAL: Nov 21 1916

20. UNDERTAKER: Mrs Christensen & Smith
ADDRESS: R F D. # 2

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STUBS - YORK CO., PTRS. & PUBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
(No. Two miles East of Blackfoot)

File No. 15998
Registered No. 94

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alpha Barrette Jr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Aug (Month) 9 (Day) 1902 (Year)

7. AGE
Yrs. 14 Mos. 3 ds. 10
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Wisconsin

10. NAME OF FATHER
Alpha Barrette

11. BIRTHPLACE OF FATHER
(State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER
Wilhelmina Lindig

13. BIRTHPLACE OF MOTHER
(State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alpha Barrette
(Address) Blackfoot Ida.

15.
Filed Nov 20 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on ..... 191...,
and that death occured on the date stated above, at 2.30 P M.
The CAUSE OF DEATH* was as follows:
Shock from
Gun shot wound in
head Accidental
Instantly Killed (Duration) ..... Yrs. ..... mos. ..... ds.
To fires
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) E J Erickson M.D.
19... (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland Cemetery — DATE OF BURIAL: Nov 22 1916

20. UNDERTAKER: E J Rick — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 15999
Registered No. 95

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. Blackfoot Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lars L. Lassmerdh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Married

6. DATE OF BIRTH. June (Month) 15 (Day) 1882 (Year)

7. AGE 34 Yrs. 4 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Hunt

11. BIRTHPLACE OF FATHER (State or Country) Kent Kans

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) B. J. Lassmerdh
(Address) Blackfoot Idaho

15. Filed Nov 20 1916 W. E. Guthrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1916, to Nov 19 1916, that I last saw her alive on Nov 19 1916, and that death occured on the date stated above, at 6:30 P M.

The CAUSE OF DEATH* was as follows:

Brights disease

(Duration) — Yrs. 4 mos. — ds.

Contributory (Secondary) —

(Duration — yrs. — mos. — ds.

(Signed) F. A. McCaig M. D.

11/19 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fairview Cemetery	Nov 22 1916
20. UNDERTAKER E J Funk	ADDRESS Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

90

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 12194

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16000

Registered No. 46

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

(No. Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James R Briley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7. AGE: 72 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. M. Rynder

(Address) Blackfoot Idaho

15.

Filed Nov 19 1916

M. E. Davis
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6th 1915, to Nov 19 1916, that I last saw h.... alive on Nov 19th 1916, and that death occured on the date stated above, at 3:20 A.M.

The CAUSE OF DEATH* was as follows:

Exhaustion — Senile Decay

Duration ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

Duration 2 yrs. ..... mos. ..... ds.

(Signed) D. M. Rynder M. D.

11-19-1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 17 ...yrs.....mos.....days. In the State 31 ...yrs.....mos.....days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Blackfoot Idaho Co

19. PLACE OF BURIAL OR REMOVAL: Iona City Cemetery — DATE OF BURIAL: Nov 22 1916

20. UNDERTAKER: E J Funk — ADDRESS: Blackfoot

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V. S. No. 5-25 M

CERTIFICATE OF DEATH.

PLACE OF DEATH.

County of Bingham

City of Blackfoot

Registration District No. 126

Primary Registration District No. 1007

(No. ..., South Shilling Ave St.)

...ureau of Vital Statistics

File No. 16001

Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Maria Gould

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. July (Month) 23 (Day) 1841 (Year)

7. AGE: 75 Yrs. 9 Mos. ds.

IF LESS than 1 day how many ...hrs. or ...min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: John Van Vorhis

11. BIRTHPLACE OF FATHER (State or Country): N Y.

12. MAIDEN NAME OF MOTHER: Elvira Fisher

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M. E. Boyd

(Address) Blackfoot Ida.

15.

Filed Nov 28 1916

W. E. Petrie
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1916, to Nov 21 1916, that I last saw h[illegible] alive on Nov 21 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonitis.

(Duration) ... Yrs. ... mos. 4 ds.

Contributory (Secondary) Lagrippe

(Duration) ... yrs. ... mos. ... ds.

(Signed) H J Simmons M. D.

11/21 1916 (Address) Blackfoot,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs ...mos ...days. In the State ...yrs ...mos ...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salomon Kansas — DATE OF BURIAL ... 191...

20. UNDERTAKER: E J Rick — ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state of OCCUPATION is very important. See instructions on back of certificate.

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SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 16002
Registered No. 98

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. Idaho Insane Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marian Bennett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH.
Unknown (Month) (Day) 1 (Year)

7. AGE
61 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thos Poynter
(Address) Blackfoot Ida

15.
Filed Nov 28 1916 W. E. Parker Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6 1915, to Nov 26 1916, that I last saw her alive on Nov 26 1916, and that death occured on the date stated above, at 3:10 A.M.

The CAUSE OF DEATH* was as follows:
Pyemia

(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Melancolia
(Duration 3 yrs. ..... mos. ..... ds.

(Signed) Thos Poynter M. D.
19 ..... (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 3 yrs. 8 mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Buried Idaho
Former or usual residence Buried Idaho

19. PLACE OF BURIAL OR REMOVAL: Asylum cemetery — DATE OF BURIAL: 11 24 1916

20. UNDERTAKER: C. D. Farrell — ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16003

Registered No. 99

Registration District No. 121

Primary Registration District No. 1007

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot (No. 493 South Shelley St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William M Keith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. 11 (Month) 28 (Day) 1835 (Year)

7. AGE: 81 Yrs. 8 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York. U.S.A.

10. NAME OF FATHER: Lyman Keith

11. BIRTHPLACE OF FATHER (State or Country): N Y

12. MAIDEN NAME OF MOTHER: Jane Moore

13. BIRTHPLACE OF MOTHER (State or Country): N Y

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Kingsbury

(Address)

15. Filed Nov 28 1916 W. O. Tate Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1916, to Nov 28 1916, that I last saw him alive on Nov 27 1916, and that death occured on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows: Apoplexy
Was sick with slight bronchitis with marked hardening and enlargement of bronchial tubes

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary) Arteriosclerosis

(Duration) Yrs. 1 mos. ds.

(Signed) C. A. T. Logan M. D.

11-28 1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: White Hall N.Y. DATE OF BURIAL 191

20. UNDERTAKER: E J Rick ADDRESS Blackfoot

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 16004
Registered No. 160

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot, R. F. D 2 (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christina Jensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Apr (Month) 12 (Day) 1849 (Year)

7. AGE: 67 Yrs. 7 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Before illness housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: C. M. Christiansen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Cantsay

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jens C. Jensen
(Address) Blackfoot R. F. D 2

15. Filed Nov 29 1916 W. E. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
11 (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1916, to ..... 191..., that I last saw h.. alive on Aug 3 1916, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Cancer of Uterus. was called to see this patient as above and told that no cure was given and all that could be done was to make her comfortable
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) 3 yrs. ..... mos. ..... ds.
(Signed) C. A. Bagley M. D.
11-29 1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Thomas Riverside Blackfoot DATE OF BURIAL Dec 6 191

20. UNDERTAKER C M Jensen ADDRESS Blackfoot Ida R.F.D. No 2

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 9128
File No. 16005
Registered No.

1. PLACE OF DEATH.
County of Elmira
City of Kamiah
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Urquhart

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 77 yrs. cont. mos. ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Robert Urquhart

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Isabel Oglevie

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Celt Urquhart
(Address) Kamiah Idaho

15.
Filed 12/4 191 6 W. F. McMahan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec. (Month) 3 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/1/16 191.., to Dec 191 6., that I last saw him alive on Dec 2 191 6, and that death occurred on the date stated above, at 4-6 M.

The CAUSE OF DEATH* was as follows:

Myocarditis
Mitral Insuf

(Duration) ..... yrs. 1 mos. 7 ds.

Contributory (Secondary) .....
(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) O. O. Bryan M. D.
19.. (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kamiah Cem. DATE OF BURIAL: 12/4/191 6

20. UNDERTAKER: C. J. Johnson ADDRESS: Kamiah, Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Kamiah

Registration District No. 49
Primary Registration District No. 4128
(No. ....., ... St.)

File No. 16006
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Obet Artell.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 19 (Day) 1895 (Year)

7. AGE: 21 yrs. 1 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student at Carlisle
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Stevens Artell

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Charlotte Whitman

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Milton S. George
(Address) Stites Idaho

15.
Filed 11/18 1916 W. J. McMahan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 11 (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ ..... 191..., ~~to~~ June 15th 1916
that I last saw him alive on June 1916
and that death occurred on the date stated above, at 12:10 M.

The CAUSE OF DEATH* was as follows:
Cause not known. Had slight injury at School. Came home. Death was probably of tubercular origin.
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. McMahan M. D.
11/18 1916 (Address) Kamiah Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind. Cem. No. 1
DATE OF BURIAL: 11/17 1916

20. UNDERTAKER: O. J. Johnson
ADDRESS: Kamiah Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2007

File No. 16007

City of ( )

(No. ....., ... St.)

Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Clark

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Wid

6. DATE OF BIRTH: Feb (Month) 8 (Day) 1847 (Year)

7. AGE: 69 yrs. 9 mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Joseph Wells

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Edizabeth Laughlin

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Levi Stephens
(Address) R. F. D. 4 Parma, Ida.

15. Filed Nov 30 1916 Ruth Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1916, to Nov 27 1916, that I last saw her alive on Nov 27 1916, and that death occurred on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Saragin M. D.

19 .... (Address) Nyssa Ore

*State the DISEASE CAUSING DEATH; or if deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Parma Ida — DATE OF BURIAL: Nov 30 1916

20. UNDERTAKER: Peckham Case — ADDRESS: Parma Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

Registration District No. 120

County of Cassia

Primary Registration District No. 2199

File No. 16008

City of Churchill

(No. ..... St.)

Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth B Cleary

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH. Oct (Month) 25 (Day) 1846 (Year)

~~Nov~~ 7 1916

7. AGE 70 Yrs. ..... Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Chas Bradshaw

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Ann Whittal

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15.

Filed Nov. 14 1916 Florence Dahlquist Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1916, to Nov 4 1916, that I last saw her alive on Oct 29 1916, and that death occured on the date stated above, at 2:10 P M.

The CAUSE OF DEATH* was as follows:

Cancer of rectum

(Duration) 1 Yrs. 5 mos. ds.

Contributory (Secondary) Old age 70 years

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Lavengwalter M. D.

Nov 4 1916 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL Hymn Ut — DATE OF BURIAL Nov 9 1916

20. UNDERTAKER R W Watt — ADDRESS Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & STNR. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16009
Registered No. .....

1. PLACE OF DEATH.
County of Cassia
City of Oakley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 20
Primary Registration District No. 2199
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Comfort Hope Devine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH. June (Month) 9 (Day) 1859 (Year)

7. AGE: 57 Yrs. 5 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Paul Van Curen

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Elvira Feeples. Comfort Hope Van Curen

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ellen Morgan
(Address) Franklin Franklin Co. Ida.

15.
Filed Nov 26 1916 Florence Dahlquist Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 8 1916, to Nov. 19 1916, that I last saw her alive on Nov 19 1916, and that death occured on the date stated above, at 9:30 P M.

The CAUSE OF DEATH* was as follows:
Carcinoma beginning in gall bladder & extending to Stomach
(Duration) ? Yrs. 3 mos. ..... ds.
Contributory (Secondary) Starvation
(Duration ..... yrs. 1 mos. ..... ds.
(Signed) John E. Langenwalter M. D.
Nov 17 1916 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Ida.
DATE OF BURIAL: 11/21 191

20. UNDERTAKER: Newcomb
ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STNRS. 24058

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 120

File No. 16010

County of Cassia

Primary Registration District No. 2199

City of Oakley

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lydia Jane Keim

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Dec. (Month) 24 (Day) 1861 (Year)

7. AGE: 54 yrs. 11 mos. 8 ds.

IF LESS than 1 day how many ... hrs. or ... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Quinton Nesbett

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Matilda Parks

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. N. Keim

(Address) Marion Idaho

15.

Filed Dec. 7 1916 Florence Dahlquist, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 2nd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1916, to Nov 10 1916, that I last saw h alive on Nov 10 1916, and that death occurred on the date stated above, at 5:50 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) ~~yrs.~~ 6 mos. ds.

Contributory (Secondary) Metastases

(Duration) 9 yrs. 2 mos. ds.

(Signed) W. O. Nelson M. D.

12-2 1916 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Marion Idaho | DATE OF BURIAL: Dec 3 1916

20. UNDERTAKER: A. S. Edgerton | ADDRESS: Oakley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 84

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16011

Registered No. 11

1. PLACE OF DEATH.
County of Bannock
City of Chesterfield
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lily Jane Gookin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: f

4. COLOR OR RACE: w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. X (Month) Dec (Day) 5 (Year) 1916

7. AGE ..... Yrs. ..... Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wilburn Gookin

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Jessie Bell

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Sarah Simons
(Address) Chesterfield

15. Filed 12/11 1916 W. J. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from no attendant 191..., that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Intestinal hemorrhage

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Smith M. D.

12/11 19.. (Address) Lacen Pr

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Chesterfield — DATE OF BURIAL: 12/10 1916

20. UNDERTAKER: none — ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 51
Primary Registration District No. 2130
File No. 3 16012
Registered No. 9

1. PLACE OF DEATH.
County of Canyon
City of Kirkland (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sullivan S Yost

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 16 (Day) 1866 (Year)

7. AGE: 50 yrs. 8 mos. 14 ds.
IF LESS than 1 day how many .....hrs. or .....mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Absalom

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Anna Dorsey

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E W Madsen
(Address) Payette

15.
Filed Dec 10 1916 Crispin Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 2nd 1916, to Dec. 1st 1916, that I last saw him alive on Dec. 1st 1916, and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:
Grippe Pos Pneumonic abscess + uremia

(Duration) ... yrs. ... mos. 30 ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Crispin Wright M. D.
12-1- 1916. (Address) Kirkland, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Cem. DATE OF BURIAL: 12-2 1916

20. UNDERTAKER: J N Adair ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of .....

(No. ....., ... St.)

Registration District No. 51 (31)

Primary Registration District No. 2130

File No. 3 16014

Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Clemmons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 5 (Day) 1906 (Year)

7. AGE: 10 Yrs. 3 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... At School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Pitsburg Penn

10. NAME OF FATHER Friendlee Clemmons

11. BIRTHPLACE OF FATHER (State or Country) Va.

12. MAIDEN NAME OF MOTHER Fa Josephine Loveless

13. BIRTHPLACE OF MOTHER (State or Country) Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Jas R. Mc Kinney
(Address) Payette Idaho

15.
Filed Dec. 10 1916
Griffin Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1916, to Dec 1 1916, that I last saw h[illegible] alive on Dec 1 1916, and that death occured on the date stated above, at 11.30 P.M.

The CAUSE OF DEATH* was as follows:
Fracture of skull due to injury from a mule

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. Wrightsman M. D.
12/2/ 1916 (Address) Payette, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: Dec 2 1916

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMS - YORK CO., PTRS. & SORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 58
Primary Registration District No. 2138
(No. ....., ... St.)

File No. 16015
Registered No. .....

1. PLACE OF DEATH.
County of Blaine
City of Soldier Ida
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas Albert Small

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.
Oct (Month) 3 (Day) 1916 (Year)

7. AGE
..... Yrs. 1 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER James Walter Small

11. BIRTHPLACE OF FATHER
(State or Country) Kansas

12. MAIDEN NAME OF MOTHER Ruby E Cristwell

13. BIRTHPLACE OF MOTHER
(State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James W Small
(Address) Soldier Ida

15.
Filed 11-23 1916
D P Higgs
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-10 1916, to 11-22 1916, that I last saw him alive on 11-20 1916, and that death occured on the date stated above, at 6 G. M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) — Yrs. — mos. 12 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D P Higgs M. D.
11-23 1916 (Address) Fairfield Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Soldier Ida	11-23 1916
20. UNDERTAKER	**ADDRESS**
Kig Mansell	Fairfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Richfield
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 17
Primary Registration District No. 2200
(No. ....., ... St.)

File No. 16016
Registered No. 1
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Lucich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Nov - 29 1916 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home.
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Martin Lucich.

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Anna Perrich

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15.
Filed ..... 191 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec - 2 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from never attended. 191, to 191,
that I last saw h alive on 191,
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Unknown.

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. J. Fitz M. D.
Dec 1916 (Address) Richfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Richfield
DATE OF BURIAL: Dec 3 1916

20. UNDERTAKER: Had none.
ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17
Primary Registration District No. 1100
File No. 16017
Registered No. 2

1. PLACE OF DEATH
County of Lincoln
City of Richfield
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Emmett Corley.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH
Oct (Month) 11 (Day) 1904 (Year)

7. AGE
13 yrs. 1 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Had none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Emmett Corley.

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Lucy Simonton

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Dec-10 1916 — L L Fitz — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov- 25- 1916, to Dec 1 1916, that I last saw h.. alive on Dec 1st 1916, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.
Contributory (Secondary) Invalid from Birth
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. L. Fitz M. D.
Dec 10 1916 (Address) Richfield Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Richfield	Dec 2 1916
20. UNDERTAKER	ADDRESS
Had none.	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Richfield
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 17
Primary Registration District No. 1106
(No. ....., ... St.)

File No. 1618
Registered No. 3
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Shockley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Dec Nov 28 1916 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Nathaniel Shockley.

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Lorna Arnold

13. BIRTHPLACE OF MOTHER (State or Country): New Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Dec 12 1916 May Fitz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec - 11 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from at Birth 191..., to ..... 191..., that I last saw him alive on Dec 11 1916, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Unknown.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Richfield
DATE OF BURIAL: Dec 11 1916

20. UNDERTAKER: Had none.
ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 215
County of Nez Perce Primary Registration District No. 75
City of Culdesac (No. ....., ... St.)
File No. 5 16019
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard J Miles

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH: Apr (Month) 20 (Day) 1828 (Year)
7. AGE: 88 yrs. 5 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Pennsylvania
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J F Miles
(Address) Cul de Sac. Idaho
15. Filed Oct 6 1916 L F Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 6 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sep 15 1916, to Oct 5 1916, that I last saw him alive on Oct 5 1916 and that death occurred on the date stated above, at 1a M.
The CAUSE OF DEATH* was as follows:
Chronic Gastritis
(Duration) ..... yrs. 1 mos. ..... ds.
Contributory (Secondary) Heart failure
(Duration) ..... yrs. ..... mos. 2 ds.
(Signed) L F Smith M. D.
Oct 5 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Culdesac Idaho | DATE OF BURIAL: ..... 191..
20. UNDERTAKER: M Sandland | ADDRESS: Culdesac

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3 16021
Registered No.

1. PLACE OF DEATH.
Registration District No. 75
Primary Registration District No. 2152
County of Nez Perce
City of (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles S. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: December 25 (Month) (Day) 1874 (Year)
7. AGE: 41 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or datablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Sumner Calif
10. NAME OF FATHER: Hayden Smith
11. BIRTHPLACE OF FATHER (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: Barbara G. Goo
13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John H Smith
(Address) Slickpoo John Smith
15. Filed Aug 8 1916 L F Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug 7th (Month) (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1915, to Dec 20 1915, that I last saw him alive on Oct 25 1915, and that death occurred on the date stated above, at 9 P M.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(Duration) yrs. 9 mos. — ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) L F Smith M. D.
Aug 8 1916 (Address) Culdesac

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Culdesac Ida — DATE OF BURIAL: Aug 9 1916
20. UNDERTAKER: H L Radabaugh — ADDRESS: Culdesac

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16022

Registered No. 47

1. PLACE OF DEATH.

County of Idaho

City of Kootskia

Registration District No. 106

Primary Registration District No. 2184

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Adelia Brainard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. June (Month) 25 (Day) 1847 (Year)

7. AGE: 69 Yrs. 4 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... At Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Lenard Baker

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Otis B Brainard

(Address) Kootskia Ida

15.

Filed Nov 21 1916

J M Culbertson
Local Registrar

SYMS - YORK CO., PTFS. & BOBS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 21 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1916, to Nov 21 1916, that I last saw her alive on Nov 20 1916, and that death occured on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

.....

.....

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) J M Culbertson M. D.

Nov 21 1916 (Address) Kootskia Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dudlow N. Y.	Nov 26 1916
20. UNDERTAKER	ADDRESS
Geo Feeney	Kootskia Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 106
Primary Registration District No. 2124
(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16023
Registered No. 48

1. PLACE OF DEATH.
County of Idaho
City of Stites

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (Unnamed female infant of J. S. Rooney)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. October 31 (Month) (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 17 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. S. Rooney

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Maud Prettyman

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. S. Rooney
(Address) Stites Idaho

15. Filed Nov 22 1916
J. M. Weberknecht
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 1st (Day) 1916 (Year)
At about one p.m.

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ investigated death of decedent on Nov. 2 1916, ~~191~~, to ~~191~~, that I last saw ~~him~~ alive on ~~191~~, and that death occurred on the date stated above, at ~~M.~~

The CAUSE OF DEATH* was as follows:
Strangulation by means of a cord around the neck with Homicidal intent

— (Duration) — Yrs. — mos. — ds.

Contributory (Secondary) —

— (Duration) — yrs — mos — ds.

(Signed) W. M. Lamar M. D.
Nov 2, 1916 (Address) Kentonville, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Stites Idaho — DATE OF BURIAL: Nov 3 1916

20. UNDERTAKER: Wm Rooney — ADDRESS: Stites

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16024
Registered No.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.
City ~~County~~ of Montpelier
~~County~~ City of Bear Lake
Registration District No.
Primary Registration District No.
(No. Montpelier Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amy Jarvis Palmer

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: May (Month) 30 (Day) 1876 (Year)

7. AGE: 40 yrs. 5 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joshua Jarvis

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Ann Johnson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alonzo Palmer
(Address) Bloomington Idaho

15.
Filed ..... 191...
D J Sutton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 22 1916, to Nov. 25, 1916, that I last saw h er alive on Nov. 25 1916, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of body of uterus and gangrenous ovarian cyst size of orange

(Duration) 3 yrs. — mos. — ds.

Contributory (Secondary) Shock following operation of panhysterectomy and removal of cysts

(Duration) — yrs. — mos. 3½ ds.

(Signed) L H Rottendorf M. D.

Nov. 25 1916 (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 0 yrs. 0 mos. 4 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? Bloomington Idaho
Former or usual residence Bloomington Idaho

19. PLACE OF BURIAL OR REMOVAL: Bloomington
DATE OF BURIAL: 11-29 1916

20. UNDERTAKER: J Jacobsen
ADDRESS: Bloomington Id

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 47 16025

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 21 53

Primary Registration District No. 2132

County of Bear Lake

City of Paris (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilson Wallentine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH

April (Month) 1 (Day) 1915 (Year)

7. AGE

1 yrs. 7 mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... School .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Paris Ida.

10. NAME OF FATHER Robert Wallentine

11. BIRTHPLACE OF FATHER (State or Country) Paris Ida

12. MAIDEN NAME OF MOTHER Emily Davis

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Wallentine

(Address) Paris Ida

15.

Filed 11-17-1916 P. J. Lupton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 8 1916, to Nov 15 1916, that I last saw him alive on Nov 15 1916, and that death occurred on the date stated above, at 2:30 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

Following measles

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. J. Lupton M. D.

11/15 1916 (Address) Paris Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Paris Ida	11-17 1916
20. UNDERTAKER	**ADDRESS**
Bishop Coulson	Paris

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce
City of Lapwai
Registration District No. 96
Primary Registration District No. 1009
(No. Whites Hospital St.)
File No. 16026
Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. W. Woolley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH
(Month) (Day) (Year): 1

7. AGE: 25 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Brakeman
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country):

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. J. Woolley
(Address) Spokane, Wash

15.
Filed 12-10-1916 L. O. Putnam Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1916, to 1916
that I last saw him alive on Nov 5 1916
and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:
Shock and loss of blood

(Duration) One hour yrs. mos. ds.
Contributory (Secondary) Railroad accident
(Duration) yrs. mos. ds.

(Signed) J. R. Loomis M. D.
Nov 5 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane
DATE OF BURIAL: 1916

20. UNDERTAKER: Hasson
ADDRESS: Lewiston

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16027
Registered No. 38

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Verhaar

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: April 7 1850 (Month) (Day) (Year)

7. AGE: 66 yrs. 7 mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Frank Riviland

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A. J. Hoffman
(Address) Greenbrook Ida

15. Filed 12-10-1916 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 8 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1916, to Nov 8 1916
that I last saw her alive on Nov 7 1916
and that death occurred on the date stated above, at 12 35 M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Liver and Gall Bladder

(Duration) yrs. 4 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Elmer G Braddock M. D.
Nov 8 1916 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos. 11 ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? Cottonwood
Former or usual residence Cottonwood

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Ida
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: J Larson
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16028

Registered No. 39

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

Registration District No. 9C

Primary Registration District No. 1009

(No. St. Joseph Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Irene Barnes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March (Month) 7 (Day) 14 (Year)

7. AGE: 2 yrs. 8 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Walla Walla

10. NAME OF FATHER: L D. Barnes

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Bessie Mulkey

13. BIRTHPLACE OF MOTHER (State or Country): Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L D Barnes
(Address) 1318 1st

15. Filed 12-10-1916 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 11th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1916, to Nov 11th 1916, that I last saw h[illegible] alive on Nov 10th 1916 and that death occurred on the date stated above, at 4-30 AM.

The CAUSE OF DEATH* was as follows:
Abscess of brain

..... (Duration) ..... yrs. 4 mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. Perkins M. D.

..... 19..... (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Nov 12 1916

20. UNDERTAKER: C J Vassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16029
Registered No. 40

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
Registration District No. 9c
Primary Registration District No. 16
(No. 0315 - 12th St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Ethel H Simmons

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Feb (Month) 10 (Day) 1882 (Year)
7. AGE: 34 yrs. 9 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country):
10. NAME OF FATHER: Waring
11. BIRTHPLACE OF FATHER (State or Country): Not known
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William D Lyle
(Address) Lapwai Ida.
15.
Filed 12-10-1916 L O Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 14 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 11 1916, to Nov 14 1916
that I last saw h[illegible] alive on Nov 11 1916
and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:
Peritonitis
(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) not known
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John B. Alley M. D.
Nov 14 1916 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: Nov 15 1916
20. UNDERTAKER: Clyde Vernon — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK C... ERS & BINDERS. BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16030
Registered No. 41

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston (No. 312, Adams St.)
Registration District No.
Primary Registration District No. 1000

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs T F Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Widow

6. DATE OF BIRTH: Dec (Month) 5 (Day) 1858 (Year)

7. AGE: yrs 57 mos. 11 ds. 11
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Car

10. NAME OF FATHER: Jesse Greer

11. BIRTHPLACE OF FATHER (State or Country): North Car

12. MAIDEN NAME OF MOTHER: Martha Carlton

13. BIRTHPLACE OF MOTHER (State or Country): Not Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T F Nelson
(Address) Gifford R T D 2

15. Filed 12-10-1916 L J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1916, to Nov 16 1916 that I last saw her alive on Nov 15 1916 and that death occurred on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) Not Known yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Elmer G Broddock M. D.

Nov 16 1916 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Watsonville Cal — DATE OF BURIAL: Nov 1916

20. UNDERTAKER: C J Vasar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 95

Primary Registration District No. 1007

File No. 16031

Registered No. 42

County of Nez Perce

City of Lewiston

(No. Orchards St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Huckman Verdin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: [redacted]

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. June (Month) 3 (Day) 1845 (Year)

7. AGE: 76 Yrs. 5 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: [redacted]ford Verdin

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Elizabeth Wilson

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora B Jackson

(Address) Lewiston Idaho

15.

Filed 12-10- 1916

R J Perkins
Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 16th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16 1916, to Nov 16 1916, that I last saw him alive on Nov 16 1916, and that death occured on the date stated above, at 6.05 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Arteriosclerosis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O C Carrasco M. D.

1916 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 7 days. In the State ..... yrs. ..... mos. 7 days.

Where was disease contracted if not at place of death?

Former or usual residence: Goldendale Wash.

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho

DATE OF BURIAL: Nov 19 1916

20. UNDERTAKER: C J Vasser

ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1602
(No. .... St.)

File No. 16032
Registered No. 43

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Taylor Nichols

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ~~11~~ 26 1916 (Month) (Day) (Year)

7. AGE 64 Yrs. 1 Mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Emmett Hardware

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Joseph Nichols

11. BIRTHPLACE OF FATHER (State or Country) Prussia

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. F. Hawes
(Address) Deweyville, Idaho

15. Filed 12-10- 1916 L. L. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1914, to 11/26/1916, that I last saw h[illegible] alive on 11/20/1916, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Failing Compensation
Arterio Sclerosis
(Duration) Yrs. mos. ds.
Contributory (Secondary) Asthma, Arteriosclerosis
(Duration) Yrs. mos. ds.
(Signed) J. F. Hawes, M. D.
11/27/1916 (Address) Deweyville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Lewiston — DATE OF BURIAL Nov 27 1916

20. UNDERTAKER C. J. Vassar — ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9C
Primary Registration District No. 1609
File No. 16033
Registered No. 494

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. White Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Schuyler E Dingley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. (Month) Mar (Day) 23 (Year) 1916
7. AGE: Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Lewiston Idaho
10. NAME OF FATHER: John H Dingley
11. BIRTHPLACE OF FATHER (State or Country): N Y
12. MAIDEN NAME OF MOTHER: Mary J Deese
13. BIRTHPLACE OF MOTHER (State or Country): Penn
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John H Dingley
(Address) 362 15th St.
15. Filed 12 = 10 = 1916
E J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Nov (Day) 27 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1916, to Nov 25 1916, that I last saw her alive on Nov 25 1916, and that death occured on the date stated above, at 11 A M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) None
(Duration ..... yrs. ..... mos. 4 ds.
(Signed) Edgar L White M. D.
Nov 27 1916 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: Nov 28 1916
20. UNDERTAKER: C J Vassar
ADDRESS: Lewiston

BYRNS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16034

Registered No. 45

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1002

(No. Porter Block, Main St.)

2. FULL NAME W H Kimbrough

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH.

July (Month) 7 (Day) 1873 (Year)

7. AGE

43 Yrs. ... Mos. 4 ... ds. 23

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Restaurant Prop

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Mo

10. NAME OF FATHER H. W. Kimbrough

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Sara Herndon

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs W H. Kimbrough

(Address) Lewiston Ida

15.

Filed 12-10-1916 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. (Month) 30th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1914, to Nov. 30 1916, that I last saw h— alive on Nov. 30 1916, and that death occured on the date stated above, at 6. a. M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(Duration) 4 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) L J Perkins M. D.

12/1 1916 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: Dec 1 1916

20. UNDERTAKER: C J Vassar — ADDRESS: Lewiston

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16035

Registered No. 23

1. PLACE OF DEATH.

County of Blaine.

City of Near Bellevue.

Registration District No. 21

Primary Registration District No. 2022

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Lilya.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 28. (Day) 1903 (Year)

7. AGE: 12 Yrs. 11 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min:?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Near Bellevue.

10. NAME OF FATHER Victor L. Lilya.

11. BIRTHPLACE OF FATHER (State or Country) Sweden.

12. MAIDEN NAME OF MOTHER Mary Donnelly.

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Victor Lilya

(Address) Gannett Blaine.

15. Filed Dec. 13 1916 Robert N. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 9th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Drowned 191... to death. 191....., that I last saw h... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Drowned

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. W. Kerrigan M. D.

July 9 1916 (Address) Hailey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spring Creek — DATE OF BURIAL: July 11 1916

20. UNDERTAKER: R N Harris — ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Blaine

City of Hailey

Registration District No. 21

Primary Registration District No. 2022

(No. .... St.)

File No. 16036

Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Welch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Aug (Month) 15 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Hailey -

10. NAME OF FATHER F W Welch

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Florence Low -

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. G. Welch

(Address) Hailey Ida

15. Filed Dec 13 - 1916 Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h[illegible] alive on Aug 15 1916,

and that death occured on the date stated above, at 2. P M.

The CAUSE OF DEATH* was as follows: Premature birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

(Address) [illegible] Hailey

*State [illegible] CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS [illegible] and (2) whether [illegible] ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey — DATE OF BURIAL: Aug 16 1916

20. UNDERTAKER: P D Harris — ADDRESS: Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
(No. ....., ... St.)

File No. 16037
Registered No. 25

1. PLACE OF DEATH.
County of Blaine
City of Hailey

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Wrech

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 8 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Hailey

10. NAME OF FATHER J W Wrech

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Florence Lowe

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. W. Wrech
(Address) Hailey Ida

15. Filed Dec 13 1916 Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on Aug 15 4 PM 1916
and that death occured on the date stated above, at 9 PM.
The CAUSE OF DEATH* was as follows:

Born Prematurely

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) J J Clemens M. D.
19.... (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida
DATE OF BURIAL: Aug 16 1916

20. UNDERTAKER: R. D. Harris
ADDRESS: Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STUBS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
(No. ..... St.)

File No. 16038
Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bearie
City of Hailey

2. FULL NAME John Chilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (- -)
(Month) (Day) 1 (Year)

7. AGE about 74 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Walter Bonning Jr.
(Address) Ketchum Ida

15. Filed Dec - 13 1916 Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1916, to Aug. 2- 1916, that I last saw h. living alive on Aug 2- 1916 and that death occured on the date stated above, at 5. P.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) 10 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.
8/3 1916 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ketchum — DATE OF BURIAL: Aug 4 1916

20. UNDERTAKER: R D Harris — ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

6-1168 — YORK CO., PTRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 16039
Registered No. 27

1. PLACE OF DEATH.
County of Blaine
City of Near Blaine
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Higgs.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Mar. 16. 1875 (Month) (Day) (Year)
7. AGE: 41 Yrs. 6 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Wales.
10. NAME OF FATHER: Richard Higgs.
11. BIRTHPLACE OF FATHER (State or Country): Wales.
12. MAIDEN NAME OF MOTHER: Margaret Brown.
13. BIRTHPLACE OF MOTHER (State or Country): Wales.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Margaret Higgs Herrs.
(Address) Bellevue Ida
15. Filed Nov 13 1916 Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 19 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Accidental Gunshot in abdomen.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.
9/19/16 (Address) Co Coroner - Hailey - Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellevue, Ida — DATE OF BURIAL: Sept 21 1916
20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2 1604

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood
(No. , St.)
Registration District No. 103
Primary Registration District No. 2183
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Rothlisberg

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH: April (not known) 1883 (Month) (Day) (Year)
7. AGE: 33 yrs. 6 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Stockbuyer
(b) General nature of industry business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Texas
10. NAME OF FATHER: Chris Rothlisberg
11. BIRTHPLACE OF FATHER (State or Country): Switzerland
12. MAIDEN NAME OF MOTHER: Mary A Harlen
13. BIRTHPLACE OF MOTHER (State or Country): Switzerland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Rothlisberg
(Address) Granville Ida
15.
Filed Nov 16 1916 H Wolfe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 15th 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov. 14th, 1916, to Nov. 15th, 1916, that I last saw him alive on Nov. 15th, 1916, and that death occurred on the date stated above, at 1 25 P. M.

The CAUSE OF DEATH* was as follows:
Ileac Perforation of Stomach
(Duration) 24 hours yrs. mos. ds.
Contributory (Secondary) Peritonitis Appendicitis
(Duration) 24 hours yrs. mos. ds.
(Signed) J. W. Turner, M. D.
Nov. 16th 1916 (Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Granville Ida
DATE OF BURIAL: Nov 17 1916
20. UNDERTAKER: A H Mann
ADDRESS: Cottonwood

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16042
Registered No.

1. PLACE OF DEATH. Registration District No. 105
County of Idaho Primary Registration District No. 2183
City of Cottonwood (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Agnes Blanche Lute

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 26 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Harrison F. Lute

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Adele G. Echerman

13. BIRTHPLACE OF MOTHER (State or Country): Java

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harrison F. Lute
(Address) Cottonwood, Ida.

15. Filed Nov 20 1916 W Bonner
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 19th (Day), 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 28th, 1916., to Nov. 19th, 1916. that I last saw her alive on Nov. 19th, 1916., and that death occurred on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:
Icterus neonatorum

(Duration) ..... yrs. ..... mos. 22 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Turner M. D.
Nov. 20th 1916 (Address) Cottonwood, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood — DATE OF BURIAL: Nov 20 1916

20. UNDERTAKER: J. H. Shaw — ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16043
Registered No.

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME De La Grange

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
male	white	

6. DATE OF BIRTH: Oct. (Month) 4 (Day) 1916 (Year)

7. AGE: — yrs. — mos. 24 hours. ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Frederick De La Grange

11. BIRTHPLACE OF FATHER (State or Country) Michigan

12. MAIDEN NAME OF MOTHER Virginia Hull

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) Kellogg Idaho

15. Filed 10/25 1916 Geo S Lester Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 4 1916, to Oct 5 1916, that I last saw h[illegible] alive on Oct 4 — 1916 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Acute Heart failure
45 min
(Duration) — yrs. — mos. — ds.
Contributory (Secondary) Exhaustion
(Duration) — yrs. — mos. — ds.
(Signed) E. E. Hardy M. D.
Oct 7 1916 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191...

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & RDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 173
Primary Registration District No. 7701
File No. 16044
Registered No. ____

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2.- FULL NAME Louis Chiara

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Mar (Month) 10 (Day) 1910 (Year)

7. AGE: Yrs. 6 Mos. 7 ds. 21
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pueblo, Colo.

10. NAME OF FATHER: Louis Chiara

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Catherine Linder

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Chiara
(Address) Kellogg

15. Filed Nov 29 1916 Geo. S. Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1916, to Oct 31 1916, that I last saw him alive on Oct 31 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Heart Disease,

(Duration) Yrs. ____ mos. 1 ds.

Contributory (Secondary)
(Duration) ____ Yrs. ____ mos. ____ ds.

(Signed) Geo. S. Lesher M. D.
10/31 1916 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg — DATE OF BURIAL: Nov 2 1916

20. UNDERTAKER: Thornhill — ADDRESS: Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 3-15 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2153
File No. 16045
Registered No. 926

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Breen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Mail	White	Married

6. DATE OF BIRTH. March (Month) 17th (Day) 1871 (Year)

7. AGE 45 Yrs. ..... Mos. 8 ..... da. 3
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Lbr Mills

9. BIRTHPLACE (State or Country) Canada.

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. H. Casey
(Address) .....

15.
Filed Nov 26 1916 M McKinnon Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Fracture Skull: Struck by Rolling Log accidental.

.....(Duration) ..... Yrs. ..... mos. ..... da.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... da.

(Signed) W. M. Shafer M. D.
10/17 1916 (Address) Hope Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Idaho	Nov 21 1916

20. UNDERTAKER	ADDRESS
E. M. Brown	S.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

mch.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16046

Registered No. 927

1. PLACE OF DEATH.

County of Bonner

City of Sandpoint

(No. ..... St.)

Registration District No. 78

Primary Registration District No. 2135

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Phoebe Jane Johnson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 13 (Day) 1861 (Year)

7. AGE. 54 Yrs. 11 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Harry Vosper

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER: Mary Jane Owens

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Johnson
(Address) Meadow Creek Idaho

15.
Filed Nov 16 1916 W. I. McKinney Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Endocarditis
Under Cerebri

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm. Rees M. D.
Nov 17 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Colburn Idaho
DATE OF BURIAL: 11/17 1916

20. UNDERTAKER: E. R. Brown
ADDRESS: S.P.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16047
Registered No. 928

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
[redacted]tration District No. 7 8
Primary Registration District No. 2155
(No. Jackson's Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilhelmina Esther Robinson
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Sept. (Month) 12 (Day) 1884 (Year)

7. AGE: 31 yrs. 2 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher and housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Frederick M. Heidel

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Ursula. Sachs

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Catherine E. Jenkins
(Address) Sandpoint Ida.

15. Filed Nov 20 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 17- 1916, to Nov 20 1916
that I last saw her alive on Nov 20 1916
and that death occurred on the date stated above, at 3³⁵ P. M.

The CAUSE OF DEATH* was as follows:
Heart failure after confinement
3 hours
..... (Duration) ..... yrs. ..... mos. 2 ds.
Contributory Confinement
(Secondary)
..... (Duration) R.F. yrs. ..... mos. 2 ds.
(Signed) R F Jackson M. D.
11/20 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillsboro - Ore. DATE OF BURIAL: 11/20 1916

20. UNDERTAKER: E M Brown ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16048.

Registered No. 929

1. PLACE OF DEATH.

Registration District No. 28

Primary Registration District No. 21337

County of Bonner

City of Sandpoint (No. ....., ... St.)

If death occure away from usual residence, give facts called for under special information.

2. FULL NAME Mr. Cesar Chaney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 32 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ontario

10. NAME OF FATHER: Tom Northcutt

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Carline Watley

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. W. Chaney

(Address) Sandpoint RFD 1

15.

Filed Nov 26 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1916, to Nov 25 1916, that I last saw her alive on Nov 25 1916, and that death occured on the date stated above, at 8 55 A.M.

The CAUSE OF DEATH* was as follows:

Toxaemia Acute Fibroids

Uterus pressing on bowels

Causing Obstruction of bowels

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Fibroids Uterus

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. McKinnon M. D.

Nov 26 1916 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho | DATE OF BURIAL: 11/28 1916

20. UNDERTAKER: Geo Brown | ADDRESS: Sp

BYRD - YORK CO., PTRS. & BOOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 78 Jan Boise

Primary Registration District No. 2155

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16049

Registered No. 930

1. PLACE OF DEATH.

County of Bonner

City of Sandpoint

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Foster

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. March (Month) ..... (Day) 1852 (Year)

7. AGE: 64 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cruiser—

(b) General nature of industry, business, or establishment in which employed (or employer): Lumber Cruiser

9. BIRTHPLACE (State or Country): Canada—

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Moore—

(Address) Lake St. City

15.

Filed Nov 27 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3 years ago 191..., to Nov 26 1916,

that I last saw him alive on ..... 191....,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Fibrosis. Sclerosis

of Lungs. Liver, Kidneys

(Duration) 3 Yrs. + mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

19.... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho — DATE OF BURIAL: Nov 29 1916

20. UNDERTAKER: E M Brown. — ADDRESS: S. P.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-1[illegible]

CERTIFICATE OF DEATH.

Registration District No. 7 8 Page

Primary Registration District No. 2135

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16050

Registered No. 231

1. PLACE OF DEATH.

County of Bonner

City of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Joyce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 22 Yrs. 1 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Patrick Joyce

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Rebecca Mayberry

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hugh Earley

(Address) .....

15. Filed Nov 28 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21 1916, to Nov 27 1916, that I last saw him alive on Nov 27 1916, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) —

(Duration) ..... mos. ..... ds.

(Signed) O. F. Voyer M. D.

19..... (Address) Sandpoint Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho. DATE OF BURIAL: 11/30 1916

20. UNDERTAKER: E M Brown ADDRESS: [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS - YORK CO., PTRS. & BKBS. 24654

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16051
Registered No. 992

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
(No. ....., ... St.)
Registration District No. 78
Primary Registration District No. 2135

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amy Mildred Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~

6. DATE OF BIRTH: May (Month) 16 (Day) 1902 (Year)

7. AGE: 13 yrs. 7 mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Killyard, Washington

10. NAME OF FATHER: J. F. Johnson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Ina Nystrom

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Johnson
(Address) Sandpoint

15. ~~Nov~~ Oct 29
Filed ~~Nov~~ 29 1916 M. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1916, to Oct 28 1916
that I last saw her alive on Oct 28 1916
and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:

Diabetic Mellitus

..... (Duration) ..... yrs. 6 mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. M. Williams M. D.
Nov 1 1916 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: Oct 30 1916

20. UNDERTAKER: E. M. Brown — ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1811
(No. County Home St.)

File No. 16052
Registered No. 68
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Linnaeus Spratt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH
(Month) (Day) 1842 (Year)

7. AGE
74 yrs. mos. ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. A. Frazee
(Address)

15. Filed Nov 29 1916 D. F. Ross Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 10th 1916, to Nov. 28th 1916, that I last saw him alive on Nov. 26 1916, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach.

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. H. Carithers M. D.
Nov 29 1916 (Address) Moscow, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 23 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Nov 30 1916
20. UNDERTAKER: Glen Grice — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61

Primary Registration District No. 10 11

File No. 16053

Registered No. 67

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. Campbell House St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Michael Goheen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Not Known

6. DATE OF BIRTH: 1860
(Month) (Day) (Year)

7. AGE: 56 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. A. Frazee
(Address)

15. Filed Nov 29 1916 D. F. Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 29 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 24 1916, to Nov. 29th 1916, that I last saw him alive on Nov 24th 1916, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Valvular Insufficiency (Heart)
Arteriosclerosis
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. H. Carithers M. D.
Nov 29th 1916 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 16 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Nov 29 1916

20. UNDERTAKER: Eden Price | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 -20M.1-15-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of ... (No. ... St.)
If death occurred in a hospital or institution, or while a transient, give name of same instead of street and number. 2. FULL NAME George Bantahe

Registration District No. 61
Primary Registration District No. 1011
File No. 16054
Registered No. 66
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH
Sept 22 (Month) (Day) 1833 (Year)

7. AGE
83 yrs. 2 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Mechanic
(b) General nature of industry business, or dstablishment in which employed (or employer) Retired

9. BIRTHPLACE (State or Country) Medina Co. Ohio

10. NAME OF FATHER Jacob Bantahe

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Mary Dirk

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William E. Hand
(Address) .....

15. Filed Nov 28 1916 D. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1916, to called out 191, that I last saw him alive on Sept 30 1916, and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Chronic Endocarditis

(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary) Old Age
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. N. Clarke M. D.
11-27-1916 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Moscow | DATE OF BURIAL Nov. 28 1916
20. UNDERTAKER Glen Price | ADDRESS Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16055

Registered No. 83

1. PLACE OF DEATH.

County of Canyon

City of Caldwell,

Registration District No 3

Primary Registration District No 1005

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mabel Helen Bridget Tremblay.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. Feb (Month) 9 (Day) 1881 (Year)

7. AGE: 35 Yrs. 9 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): London England.

10. NAME OF FATHER: William Hogan

11. BIRTHPLACE OF FATHER (State or Country): London.

12. MAIDEN NAME OF MOTHER: Alice Harley

13. BIRTHPLACE OF MOTHER (State or Country): London

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dustus Wilhelm Mombert

(Address) Caldwell, Idaho

15. Filed 11-20- 1916 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/18 1916, to 11/18 1916, that I last saw h[er] alive on 11/18 1916, and that death occured on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism

(Duration) 3 hours yrs. mos. ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Tree M. D.

11/18 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: Nov 20 1916

20. UNDERTAKER: Pedlham Care Co. ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. ..... St.)

File No. 16056
Registered No. 84

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza A. Ragsdale

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Oct (Month) 18 (Day) 1870 (Year)

7. AGE: 46 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: A. J. Redd

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Lavina Burham

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. S. Ragsdale
(Address) Greenleaf, Idaho

15.
Filed Nov. 24th 1916
John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1916, to Nov 22 1916, that I last saw her alive on Nov 22 1916, and that death occured on the date stated above, at 8-45 A.M.

The CAUSE OF DEATH* was as follows:
Chronic nephritis
Heart

(Duration) several Yrs. mos. ds.
Contributory (Secondary) dropsy
(Duration several years Yrs. mos. ds.
(Signed) J. W. Lee M. D.
Nov 23 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Nov 24 1916

20. UNDERTAKER: Peckham Care Co — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. ....., ... St.)

File No. 16057
Registered No. 85

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessi Almond Reagean

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 7 (Day) 1860 (Year)

7. AGE: 56 Yrs. 5 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): Labor

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Richard Reagean

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Dont now.

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. J. H. George
(Address) Caldwell.

15. Filed Nov. 27 1916
John S. Meyer Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1916, to Nov 25 1916, that I last saw him alive on Nov 25 1916 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Brain

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. J. Mullen M. D.

11-27-1916 (Address) Box 64 Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 11/27 1916

20. UNDERTAKER: Bilford Furn. Co. — ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16058

Registered No. 86

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1605

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maria Jane Dement

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 13 (Day) 1838 (Year)

7. AGE: 78 Yrs. 5 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bellemont Ohio

10. NAME OF FATHER: William Maden

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Hulda Maden

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate Connell

(Address) 530 So 16 Street Boise, Idaho

15.

Filed 11-29- 1916

John S. Mayes
Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 24 1916, to Nov. 28 1916, that I last saw her alive on Nov 28 1916, and that death occured on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

.....(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C M Foley M. D.

Nov 30 1916 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill

DATE OF BURIAL: 11-30 1916

20. UNDERTAKER: Binford Furn. Co.

ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ....., ... St.)

File No. 16059
Registered No. 87

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bennett W. Shemp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Jan (Month) 19 (Day) 1892 (Year)

7. AGE: 24 Yrs. 10 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Postal clerk.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Minnesota

10. NAME OF FATHER W. H. Shemp

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Wood.

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. H. Shemp
(Address) Claywell Mississippi

15. Filed Dec. 1st 1916 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1916, to Nov 29 1916, that I last saw h[illegible] alive on Nov 29 1916, and that death occured on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH* was as follows:
Peritonitis

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Ruptured Appendix

(Duration ..... yrs. ..... mos. 8 ds.
(Signed) [illegible] M. D.
11/29/1916 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Claywell Miss. DATE OF BURIAL: 191

20. UNDERTAKER: Peckham Coffin Co. ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. ..... St.)

File No. 16060
Registered No. 88

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura Burg Smith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. Nov. (Month) 3 (Day) 1836 (Year)

7. AGE: 60 Yrs. ..... Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Martin Bingraham

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Emeline Burg

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry E. Smith
(Address) Caldwell, Idaho

15. Filed Dec. 1st 1916 John G. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 15 1914, to Nov. 30 1916, that I last saw h[illegible] alive on Nov. 26 1916, and that death occured on the date stated above, at 8-20 A.M.

The CAUSE OF DEATH* was as follows:
Mitral Stenosis
Ascites -
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. D. Hoge M. D.
12/1 1916 (Address) Coldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bergennes Vermont | DATE OF BURIAL ..... 191...

20. UNDERTAKER: Peckham Bros & Caldwell | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & RDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16061

Registered No. 89

1. PLACE OF DEATH.

County of Canyon

City of Caldwell.

(No. ....., ... St.)

Registration District No. 3

Primary Registration District No. 2005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jeff Osborne

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Don't know

6. DATE OF BIRTH. About 1860
(Month) (Day) (Year)

7. AGE: About 56 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Do not know

10. NAME OF FATHER: v

11. BIRTHPLACE OF FATHER (State or Country): v

12. MAIDEN NAME OF MOTHER: v

13. BIRTHPLACE OF MOTHER (State or Country): v

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R W Lower U S R S
(Address) Caldwell Ida

15.
Filed 12-5- 1916 John S Mayes Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1916, to Nov 30 1916, that I last saw h.... alive on Nov. 30 1916, and that death occured on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) C M Talley M. D.

12-4-1916 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Bastrop Texas — DATE OF BURIAL: 12/5 1916

20. UNDERTAKER: Burford-Tarry Co — ADDRESS: Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. ..... St.)

File No. 16062
Registered No. 90

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Caldwell

2. FULL NAME Lew Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1848 (Year)

7. AGE: 68 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Jacob Brown

11. BIRTHPLACE OF FATHER (State or Country): Dont know

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Will Young
(Address) Meridian Idaho

15. Filed Dec. 9 1916 — John S. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 29 1916, to Dec 7 1916, that I last saw h/ m. alive on Dec 7 1916, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Ty phoid Fever.

(Duration) Yrs. 3 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Jansen M. D.
12/9 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Ida — DATE OF BURIAL 191

20. UNDERTAKER: Peckham Case Co — ADDRESS Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16063

Registered No. 91

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 9005

County of Canyon

City of Caldwell

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida B. Flory.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH. June (Month) 22 (Day) 1868 (Year)

7. AGE: 48 Yrs. 5 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Missouri.

10. NAME OF FATHER L. B. Forney.

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Casandra Taylor.

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. W. Flory
(Address) Caldwell Idaho.

15. Filed Dec. 9 1916 John L. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Dec (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1916, to Dec 8 1916, that I last saw her alive on Dec 8 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Acute Dementia

(Duration ..... yrs. ..... mos. 5 ds.

(Signed) S. J. Miller M. D.

12-8 1916 (Address) S. J. Miller

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairview Cemetary — DATE OF BURIAL: Dec 10 1916

20. UNDERTAKER: Peckham Coe Co — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SONS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Caldwell.

Registration District No. 3

Primary Registration District No. 2005

(No. ....., ... St.)

File No. 16064

Registered No. 92

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cynthia B Harrington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Aug (Month) 23 rd (Day) 1843 (Year)

7. AGE: 73 Yrs. 3 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass

10. NAME OF FATHER: Thomas R Torrey

11. BIRTHPLACE OF FATHER (State or Country): Mass

12. MAIDEN NAME OF MOTHER: Achasia Chatman

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Harrington

(Address) Caldwell Idaho

15. Filed Dec. 10 1916 John S. Meyer. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1916, to Dec 8 1916, that I last saw her alive on Dec 8 1916, and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) Yrs. 7 mos. ds.

Contributory (Secondary)

(Duration Yrs. 2 mos. ds.

(Signed) M. Gue M. D.

12-10 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lincoln Ida — DATE OF BURIAL: 191

20. UNDERTAKER: Buford Fur. Co. — ADDRESS: Caldwell Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16065

Registered No. 93

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

(No. ....., ... St.)

Registration District No. 3

Primary Registration District No. Yoos

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter G. Steensma

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH. Feb (Month) 14 (Day) 1845 (Year)

7. AGE: 71 Yrs. 9 Mos. 25 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Holland.

10. NAME OF FATHER Nicholas Steensma

11. BIRTHPLACE OF FATHER (State or Country) Holland.

12. MAIDEN NAME OF MOTHER Dont know.

13. BIRTHPLACE OF MOTHER (State or Country) Holland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N. P. Steensma

(Address) Caldwell, Idaho

15. Filed Dec. 12 1916 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1916, to Dec 9 1916, that I last saw him alive on Dec 9 1916 and that death occured on the date stated above, at 4-100 M.

The CAUSE OF DEATH* was as follows:

Uremia

Operated removal Prostate Gland

(Duration) 1/2 Yrs. — mos. 9 ds.

Contributory (Secondary) Bronchial Stricture

(Duration 2 yrs. — mos. — ds.

(Signed) G. D. Farmer, M. D.

12/9 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Dec 12 1916

20. UNDERTAKER: Beckham Care Co — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16066

Registered No. 28

1. PLACE OF DEATH.

County of Shoshone

City of Wallace,

Registration District No. 1225

Primary Registration District No. 2200

(No. Interstate Mine St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Failey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ...35... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER " " (State or Country)

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER " " (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C.R. Newton

(Address) Wallace, Ida.

15. Filed 11/24 1916 H.A. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 22 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 1916, to — 1916, that I last saw him alive on ..... 191..., and that death occured on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Crushed by falling rocks in Mine

(Duration) ..... Yrs. 1st Hrs. ds.

Contributory (Secondary)

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) Chas. R. Mowry Coroner

11/25 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace, Idaho	11/26 1916
20. UNDERTAKER	**ADDRESS**
Bruce G. Wardell	Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

STUDE - YOUNG CO. SYRA. N. Y. 24655

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
(No. ..... St.)

File No. 16068
Registered No. 30

1. PLACE OF DEATH.
County of Lincoln
City of Paul
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	White	Single

6. DATE OF BIRTH.
Nov. (Month) 7th (Day) 1916 (Year)

7. AGE
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 18 hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho.

10. NAME OF FATHER W. G. Hall

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Susie A. Fenchild

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. G. Hall
(Address) Paul, Ida.

15.
Filed 12-9 1916 E. H. Elmore
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 7th (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7th 1916., to Nov. 7th 1916.,
that I last saw h.. alive on Nov. 7th 1916.
and that death occured on the date stated above, at 100 M.

The CAUSE OF DEATH* was as follows:
Premature.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. C. Patterson M. D.
11-8 1916. (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Paul, Ida.	11-8-1916
20. UNDERTAKER None	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 52

County of Bear Lake Primary Registration District No. 2136

City of Montpelier 2dy (No. ....., ... St.)

File No. 16069

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Blanch P. Austen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: March 30th 1882 (Month) (Day) (Year)

7. AGE: 34 yrs. 8 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Andrew B. Peery

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Mary F McKenney

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D Mansfield
(Address) Montpelier, Idaho

15. Filed 12/5/ 1916 A H Walling Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17 1916, to Dec 4 1916, that I last saw her alive on Dec 4 1916 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Embolism of brain

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D A Lyon M. D.

12/5/1916 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida. DATE OF BURIAL: 12/6/ 1916

20. UNDERTAKER: F. Jarboe ADDRESS: Montpelier

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16070

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bear Lake
City of Bern (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2136

2. FULL NAME Mary Matalde Biemz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec 2 (Month) (Day) 1916 (Year)

7. AGE: 13 yrs. 8 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers
(b) General nature of industry business, or establishment in which employed (or employer): Daughter

9. BIRTHPLACE (State or Country): Bern Beartake Co Idaho

10. NAME OF FATHER: Rydalt Biemz

11. BIRTHPLACE OF FATHER (State or Country): Switzland Europe

12. MAIDEN NAME OF MOTHER: Emma B Maier

13. BIRTHPLACE OF MOTHER (State or Country): Switzaland Europe

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Rudolf Biemz
(Address): Bern Idaho

15.
Filed Dec 2 1916 H H Klemz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec 2 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1916., to Dec 1 1916., that I last saw her alive on Dec 1 1916. and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Bronchitis
Measels

10 (Duration) yrs. mos. ds.

Contributory (Secondary)
10 (Duration) yrs. mos. ds.

(Signed) J H Lynn M. D.
Dec 2 1916. (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 13 yrs. 8 mos. 8 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? Bern
Former or usual residence Idaho

19. PLACE OF BURIAL OR REMOVAL: Bern Idaho | DATE OF BURIAL: Dec 8 1916

20. UNDERTAKER: Ruell Kemz | ADDRESS: Bern

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
(No. ....., ... St.)

File No. 16071
Registered No. .....

1. PLACE OF DEATH
County of Bear Lake
City of Geneva
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Hellier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 17th (Day) 1866 (Year)

7. AGE: 50 Yrs. 2 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: G. C. Hellier

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Maria Lashbrook

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. J. Hellier
(Address) Montpelier

15. Filed 12/1 1916. H. H. Kluey (M.D.) Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 28th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza, Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) H. H. Kluey M. D.
12/1/1916 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Geneva, Idaho — DATE OF BURIAL: 12/2/1916

20. UNDERTAKER: Bishop Hirschi — ADDRESS: Geneva Ida.

BYNS - YORK CO., PTRS. & BOKS. 24858

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bear Lake

City of Montpelier.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32

Primary Registration District No. 2136

(No. ....., ... St.)

File No. 16072

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donald Truman Weaver.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	S

6. DATE OF BIRTH: Aug (Month) 27 (Day) 1916 (Year)

7. AGE: ..... yrs. 2 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J Evans Weaver

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Irma Welker

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Truman Weaver
(Address) Fruitland Ida

15. Filed 11/24/1916 A W King M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1916, to Nov 24 1916, that I last saw him alive on Nov 24 1916, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) Measles

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elias E. Ashton M. D.
11/24 1916 (Address) Montpelier Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier — DATE OF BURIAL: 11-28 1916

20. UNDERTAKER: Forbush — ADDRESS: Montpelier

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 5

Primary Registration District No. 2136

File No. 16074

County of Bear Lake

City of Montpelier (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Walton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W.	Single

6. DATE OF BIRTH: Nov (Month) 13 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ...6.. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... none .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Frank Dalton Jr.

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Myrtle Findlay

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fk. Dalton Jr
(Address) Montpelier Ida

15. Filed Nov. 15th 1916 H. H. Heney M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13 1916, to Nov 14 1916, that I last saw he alive on Nov 14 1916, and that death occurred on the date stated above, at 5A. M.

The CAUSE OF DEATH* was as follows:

Premature Labor. (birth)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas E. Hoffman M. D.

11/14 1916 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Montpelier Ida	Nov. 15th 1916

20. UNDERTAKER	ADDRESS
Barbach	Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2136
File No. 16075
Registered No. .....

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Phoebe Orchard

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: girl

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
February (Month) 10 (Day) 1915 (Year)

7. AGE
1 Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Bear Lake Co. Idaho.

10. NAME OF FATHER: Joseph H. Orchard

11. BIRTHPLACE OF FATHER
(State or Country) Weber Co. Utah.

12. MAIDEN NAME OF MOTHER: Catherine Young.

13. BIRTHPLACE OF MOTHER
(State or Country) Bear Lake Co. Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph H. Orchard
(Address) Montpelier Idaho.

15.
Filed Nov. 14 1916
D. H. Lyman M.D.
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13 1916, to Nov. 13 1916, that I last saw her alive on Nov 13 1916, and that death occured on the date stated above, at 12.50 M.

The CAUSE OF DEATH* was as follows:
Cancerous ulceration of unknown Origin
(Duration) 8 hours ~~Yrs.~~ ~~mos.~~ ~~ds.~~

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. H. Lyman M. D.
19..... (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho — DATE OF BURIAL: Nov 15 1916

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16076
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Morris Edwin Schoper

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE
~~yrs.~~ 3 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Baby
(b) General nature of industry business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Montpelier Ida.

10. NAME OF FATHER Geo. A. Schoper

11. BIRTHPLACE OF FATHER (State or Country) U. S.

12. MAIDEN NAME OF MOTHER Mildred Whitin

13. BIRTHPLACE OF MOTHER (State or Country) Montpelier Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. A. Schoper
(Address) Montpelier Ida

15.
Filed 11-3-1916 N. Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
11 (Month) — 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-31, 1916, to Nov. 2 1916
that I last saw him alive on Nov. 2 1916
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Pleuro-Pneumonia

..... (Duration) ~~yrs.~~ ~~mos.~~ 4 ds.

Contributory (Secondary) —
— (Duration) ~~yrs.~~ — mos. — ds.

(Signed) E. F. Burpee M. D.
..... 19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida — DATE OF BURIAL: 11-4 1916

20. UNDERTAKER: None — ADDRESS: —

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16077

Registered No. .....

Registration District No. 7

Primary Registration District No. 1006.

1. PLACE OF DEATH.

County of Canyon

City of Nampa

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marion Geneva Napper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fem	White	

6. DATE OF BIRTH. Oct (Month) 12 (Day) 1916 (Year)

7. AGE ..... Yrs. 1 Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... /
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Geo. A Napper

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Ruth G Maynard

13. BIRTHPLACE OF MOTHER (State or Country) Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. Arthur Napper
(Address) Nampa - Idaho.

15. Filed Nov 18 1916 Amos Hatfield
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov-18- 5 o'clock 1916, to Nov-18- 6 o'clock 1916, that I last saw her alive on Nov-18- 1916, and that death occured on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:
Arsenic poisoning & convulsions.

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) /

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) B Smith M. D.

11/18- 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?..... /

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn Cem	11-19 1916
20. UNDERTAKER	**ADDRESS**
Jud Robinson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. [illegible] 16-13

CERTIFICATE OF DEATH. 4

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. [illegible]

County of Canyon

Primary Registration District No. 1006

File No. 16078

City of Nampa (No. Nampa General Hospital St.)

Registered No. [illegible]

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas W. Jackson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept. (Month) 18 (Day) 1865 (Year)

7. AGE: 31 Yrs. 2 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Switchman

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: David B. Jackson

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Carrie Stenline

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. D. B. Jackson

(Address) 3100 Lawrence St. Denver Colo.

15. Filed Nov 2 1916 Amos Hatfield Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1916 to 191..., that I last saw him alive on Nov 30 1916, and that death occured on the date stated above, at 12 45 P. M.

The CAUSE OF DEATH* was as follows:

Run over by rail road car while switching - Hemorrhage of Lungs + Injury to head

(Duration) Hour Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) J. H. Murray M. D.

Nov. 30 1916 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View

DATE OF BURIAL: 12-3 1916

20. UNDERTAKER: Robinson Funeral Home

ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BKBS. 24953

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 706
Primary Registration District No. 1006.
File No. 16079
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elmer Nolan Hilty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov (Month) 7 (Day) 1916 (Year)

7. AGE ..... Yrs. 1 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. E. Hilty

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Pearl Baker

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. E. Hilty
(Address) Nampa Ida

15. Filed Dec 9 1916 Anna Hatfield Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 9th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-6 1916, to 12-9 1916, that I last saw h... alive on 12-8 1916, and that death occured on the date stated above, at 1A M.

The CAUSE OF DEATH* was as follows:
Bronchio-pneumonia

(Duration) — Yrs. — mos. 3 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G. Lin Leeson M. D.
12/9 1916. (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Boise — DATE OF BURIAL Dec 9 1916.

20. UNDERTAKER T K Robinson — ADDRESS Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 106
(No. Nampa Gen'l Hospital St.)
File No. 16080
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Willard H Austin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1859 (Year)

7. AGE: 57 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Maine

10. NAME OF FATHER Eliza Austin

11. BIRTHPLACE OF FATHER (State or Country) New Hampshire

12. MAIDEN NAME OF MOTHER Ruth Hussey

13. BIRTHPLACE OF MOTHER (State or Country) Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C L Austin
(Address) Wilson Ida

15. Filed Dec 3 1916 Anna Hatfield Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1916, to Dec 1 1916, that I last saw him alive on Dec 1 1916, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Valvular insufficiency & myocarditis
(Duration) Yrs. 6 mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H P Rose M. D.
Dec 4 1916 (Address) Nampa - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rosedale Cem — DATE OF BURIAL: 12-4-1916

20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006.
File No. 16081
Registered No. ____

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ellen Gross
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 19 (Day) 1881 (Year)

7. AGE: 35 Yrs. ____ Mos. 16 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) ____

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER J. S. Redmon

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. L. Gross
(Address) Nampa Ida

15. Filed Dec 6 1916 Anna Hatfield Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1916, to Dec 6 1916, that I last saw her alive on Dec 4 1916, and that death occured on the date stated above, at 7:30 P M.

The CAUSE OF DEATH* was as follows:
tuberculosis - generalized
9
(Duration) Yrs. 9 mos. ____ ds.
Contributory (Secondary) ____
(Duration ____ yrs. ____ mos. ____ ds.

12/7 1916 (Signed) Maurice B. Fallon M. D.
(Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho — DATE OF BURIAL ____ 191

20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16082

Registered No. .....

Registration District No. .....

Primary Registration District No. 2006

1. PLACE OF DEATH.

County of Canyon

City of Nampa (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucille Bowles

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec 5 1865
(Month) (Day) (Year)

7. AGE: 48 Yrs. — Mos. — ds.
IF LESS than 1 day how many.....hrs. or .....min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Nathan Glick

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Harriett Rogers

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. H. Bowles
(Address) Nampa Idaho,

15. Filed Nov 21 1916 Ann Hatfield
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16 1916, to Nov 20 1916, that I last saw her alive on Nov 18 1916 and that death occured on the date stated above, at 9.45 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) La Grippe & Chronic Asthma

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. J. Miller M. D.

Nov 21 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 11-22-1916

20. UNDERTAKER: Fred K. Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BSRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ..... Primary Registration District No. 2006

File No. 16083

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Bowmont (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Trazie Stafford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. yrs 81. 2. 2 1835
(Month) (Day) (Year)

7. AGE ..... Yrs. 81 ..... Mos. 9 ..... ds. 2

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER Andrew Stafford

11. BIRTHPLACE OF FATHER (State or Country) do not no

12. MAIDEN NAME OF MOTHER " " " "

13. BIRTHPLACE OF MOTHER (State or Country) New yorp

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) X W. A. Stafford
(Address) Bowmont Idaho

15. Filed Dec 2 1916 Anna Hatfield Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 2nd 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov-15- 1916, to Nov-24- 1916, that I last saw him alive on Nov-24- 1916, and that death occured on the date stated above, at 7.25 A M.

The CAUSE OF DEATH* was as follows:—
Cardiac degeneration.
following Pneumonia.

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W B Smith M. D.
12/2 1916 (Address) Marsing Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Emmett Oregon — DATE OF BURIAL ..... 191..

20. UNDERTAKER Robinson — ADDRESS Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 7

Primary Registration District No. 2006

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16084

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred K Neal Gross

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 7 (Day) 1875 (Year)

7. AGE: 41 Yrs. ..... Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Tenn

10. NAME OF FATHER: W. P. Gross

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Loenberg

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. E. Gross

(Address) Kuna Ida R.D. 1

15. Filed Nov 22 1916 Anna Hufford Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 21st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/14 1916, to 11/22 1916, that I last saw him alive on 11/21st 1916, and that death occured on the date stated above, at 11-30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage
induced by Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Lobar Pneumonia

(Duration ..... yrs. ..... mos. 10 ds.

(Signed) A. C. Robinson M. D.

11/24 1916 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL, OR REMOVAL: Sorkelawn Cem — DATE OF BURIAL: 11-23 1916

20. UNDERTAKER: Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ROBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 2006

File No. 16085

County of Canyon

City of Nampa (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Grace

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Nov (Month) 12 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. —

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER S S Grace

11. BIRTHPLACE OF FATHER (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Lina Atkinson

13. BIRTHPLACE OF MOTHER (State or Country) Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed ..... 191..

Anna Hall
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1916, to Nov 22 1916, that I last saw h... alive on Nov 22 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Insanition

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature Birth

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H C Robinson M. D.

19.... (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL ..... 191..

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 16086
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clyde Gross

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov (Month) 12 (Day) 1906 (Year)

7. AGE — Yrs. — Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER S. L. Gross

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Lama Wine

13. BIRTHPLACE OF MOTHER (State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S. L. Gross
(Address) Nampa Ida Rt. 2

15. Filed Nov 25 1916 Anna Valfield Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12 1916, to Nov 22 1916, that I last saw h[illegible] alive on Nov 22 1916, and that death occured on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:
Ptomaine poisoning
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Premature birth
(Duration ..... yrs. ..... mos. 12 ds.
(Signed) H C Robinson M. D.
11/25 1916 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wohlerlawn Cem — DATE OF BURIAL: 11-26 1916
20. UNDERTAKER: Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

STUBS-YORK CO., PTRS. & RUBS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 16087
Registered No. 44

1. PLACE OF DEATH.
County of Idaho.
City of Meadow creek (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Ruff.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Oct (Month) 16 (Day) 1893 (Year)

7. AGE: 23 yrs. 1 mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockraucher
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington.

10. NAME OF FATHER: August Ruff.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Johanna Fleder.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) meadow creek
(Address) Visit Neighbor

15. Filed Dec 2 1916 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1916, to Nov. 24 1916, that I last saw h[illegible] alive on Nov 24 1916 and that death occurred on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:
Accidental Gun Shot wound

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Strauss M. D.
11/27 1916 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Prairieview	Nov. 26 1916
20. UNDERTAKER	ADDRESS
R. J. Mango	Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Mt Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181
(No. ....., ... St.)

File No. 16088
Registered No. 43
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sadie Rice

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
F	W	Single

6. DATE OF BIRTH: July (Month) 15 (Day) 1910 (Year)

7. AGE: 6 yrs. 4 mos. 16 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mt Idaho Idaho

10. NAME OF FATHER: Walter Rice

11. BIRTHPLACE OF FATHER (State or Country): Mt Idaho Idaho

12. MAIDEN NAME OF MOTHER: ada Smith

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Rice
(Address) Mt Idaho Idaho

15. Filed dec 2 1916 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16 1916, to Nov 21 1916
that I last saw her alive on Nov 20 1916
and that death occurred on the date stated above, at 11:15 P.M.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) about 1 week yrs. mos. ds.

Contributory (Secondary) abscess about appendix

(Duration) — yrs. — mos. 5 ds.

(Signed) G S Stockton M. D.

11/22 1916 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt Idaho — DATE OF BURIAL: Nov 22 1916

20. UNDERTAKER: A J Maugg — ADDRESS: Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 1001

File No. 16089

Registered No. 4089

County of Idaho

City of Grangeville (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mariah Keltner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Oct 22 1854 (Month) (Day) (Year)

7. AGE: 62 yrs. 7 mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER William Bart

11. BIRTHPLACE OF FATHER (State or Country) Pensylvania

12. MAIDEN NAME OF MOTHER Rachel

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R B Keltner
(Address) Grangeville

15. Filed Dec 7 1916 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 5 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29 1916, to Nov 5 1916, that I last saw her alive on Nov 5 1916, and that death occurred on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

Splenomedullary
Leukemia
(Duration) unknown yrs. mos. ds.

Contributory (Secondary)
(Duration) 2 0 yrs. mos. ds.

(Signed) G S Stockton M. D.
11/6 1916 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View | DATE OF BURIAL: Nov 7 1916

20. UNDERTAKER: G S Hancock | ADDRESS: Grangeville

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16091

Registered No. 45

Registration District No. 11

Primary Registration District No. 2648

1. PLACE OF DEATH.

County of Bayette

City of Eight Mile

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME None

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Dec (Month) 6 (Day) 1 C (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ? hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... 0

(b) General nature of industry, business, or establishment in which employed (or employer)... 0

9. BIRTHPLACE (State or Country) Eight Mile

10. NAME OF FATHER Lee Simmons

11. BIRTHPLACE OF FATHER (State or Country) Idho

12. MAIDEN NAME OF MOTHER Edna Mussel

13. BIRTHPLACE OF MOTHER (State or Country) Idho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lee Simmons

(Address) Leeds Springs Id

15. Filed Dec 10 1916 Edna Lacy Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) C (Day) 191 C (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec C 191 6, to Dec C 191 6, that I last saw h- alive on Dec C 191 6, and that death occured on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows: Premature Birth

1 hr

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) None

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Edna Kaufe M. D.

Dec 6 1916 (Address) Leeds Springs Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Eight Mile

DATE OF BURIAL: Dec 6 191 C

20. UNDERTAKER: None

ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16092

Registered No. 444

Registration District No. 11

Primary Registration District No. 2648

1. PLACE OF DEATH.

County of Bannock

City of Soda Springs

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo Vailes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.)

6. DATE OF BIRTH. Dont Know (Month) ..... (Day) 1 (Year)

7. AGE '35 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Baker

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Michigan

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eric Kenley

(Address) Soda Springs Ida

15. Filed Dec 10, 1916 Eric Kenley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1916, to Nov 29 1916, that I last saw him alive on Nov 29 1916, and that death occured on the date stated above, at 5P M.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(Duration) Yrs. 5 mos. ~ ds.

Contributory (Secondary) none

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Eric Kenley M. D.

Dec 2 1916 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs. 2 mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Soda Springs Ida

19. PLACE OF BURIAL OR REMOVAL Soda Springs Ida — DATE OF BURIAL Dec 6 1916

20. UNDERTAKER Ed Watkins — ADDRESS Soda Springs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16093
Registered No. 29

1. PLACE OF DEATH.
County of Twin Falls
City of Kimberly

Registration District No. 36
Primary Registration District No.
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Elizabeth Truesdale

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: April (Month) 29 (Day) 1839 (Year)

7. AGE: 77 yrs. 7 mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fredricksburg Ohio

10. NAME OF FATHER: Peter Cramer

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Stuart

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bessie Sampson
(Address) Kimberly Idaho

15. Filed Dec. 6 1916 J. N. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 30 1916, to Dec 4 1916
that I last saw her alive on Dec 3 1916
and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. N. Davis M. D.
Dec 6 1916 (Address) Kimberly

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Twin Falls Ida. DATE OF BURIAL: Dec 8 1916

20. UNDERTAKER: P. J. Grossman ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16094
Registered No. 28

1. PLACE OF DEATH.
County of Twin Falls
City of Kimberly

Registration District No. 36
Primary Registration District No.
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Hunt "Jr." Creighton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Dec (Month) 4 (Day) 1916 (Year)
7. AGE: ....yrs....mos....ds. IF LESS than 1 day how many 5 hrs. or ....min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Joseph H. Creighton
11. BIRTHPLACE OF FATHER (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Zada Belle Prater
13. BIRTHPLACE OF MOTHER (State or Country): Penn
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. H. Creighton
(Address) Kimberly Ida
15.
Filed Dec 5 1916 J. M. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 4 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1916, to Dec 4 1916
that I last saw him alive on Dec 4 1916
and that death occurred on the date stated above, at 5:20 P.M.
The CAUSE OF DEATH* was as follows:
Premature birth
(Duration) ....yrs....mos....ds.
Contributory (Secondary)
(Duration) ....yrs....mos....ds.
(Signed) J. M. Davis M. D.
Dec 5 1916 (Address) Kimberly

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: Dec 5 1916

20. UNDERTAKER: none
ADDRESS:

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.....
Primary Registration District No.....
(No. ....., ... St.)

File No. 16095
Registered No. .....

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W Kelley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Unknown

6. DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7. AGE Unknown ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Railroad Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Dont Know

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. F. Barnes
(Address) Shoshone Idaho

15. Filed Nov 25 1916 J. L. Turner Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~Unknown~~ 7.30 PM Nov 24 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/22 1916, to 11/24 1916, that I last saw him alive on 11/24 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Acute Pneumonia

(Duration) — Yrs. — mos. 4 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Barnes M. D.
19..... (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 4 days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Don't Know

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: 11/25 1916

20. UNDERTAKER: O. L. Brannan — ADDRESS: Shoshone

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16096

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lincoln

City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME not named

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. ~~SINGLE, MARRIED, WIDOWED OR DIVORCED.~~ Single (Write the word.)

6. DATE OF BIRTH. Dec 4 1916
(Month) 8 (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds. 8

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Shoshone

10. NAME OF FATHER andrew Duff

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Marie Smith

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A D Duff
(Address) [redacted]

15. Filed Dec 5, 1916 J L Sullen Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24688

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 12th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 4 1916, to Dec. 12 1916, that I last saw him alive on Dec. 12 1916, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows: Influenza + Asthenia

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Fellows M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191.....

20. UNDERTAKER O J Brannan | ADDRESS

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16097
Registered No. 515

1. PLACE OF DEATH.
County of Ada
City of Boise

Registration District No. 20
Primary Registration District No. 2017
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Bailey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: About 25 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Woodsman
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): .....

10. NAME OF FATHER: J.C. Bailey

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

Was Bailey ever married? Was he divorced? Was he a veteran?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 12/10 1916 D.D. Drennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22 1916, to Nov 22 1916 that I last saw him alive on Nov 22 1916 and that death occurred on the date stated above, at about 9 A M.

The CAUSE OF DEATH* was as follows:

Accidental bullet wound in chest

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edw. A. Smith M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ruthdrum Idaho
DATE OF BURIAL: Nov 29 1916

20. UNDERTAKER: O.W. Stone
ADDRESS: Ruthdrum Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16098

Registered No. 574

1. PLACE OF DEATH.

County of Kootenai

City of Rathdrum

(No. ..... St.)

Registration District No. 20

Primary Registration District No. 2051

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thelma Marie Martin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED~~ OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 26 (Day) 1913 (Year)

7. AGE: 3 Yrs. ..... Mos. 3 ds. 14

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Father is Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER Daniel Martin

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Gertrude Rinhart

13. BIRTHPLACE OF MOTHER (State or Country) S. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Myrtle Foster
(Address) Rathdrum Idaho

15. Filed 12/10 1916 D D Simmons Local Registrar

BYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Nov. (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1 1916, to Nov 9 1916, that I last saw her alive on Nov 9 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Endangerment of Liver
.....
.....
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. D. Simmons M. D.
11/9 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Ida — DATE OF BURIAL: Nov 11 1916

20. UNDERTAKER: O. W. Stone — ADDRESS: Rathdrum Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16099

Registered No. 513

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Rathdrum

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 20

Primary Registration District No. 3089

(No. ....., ... St.)

2. FULL NAME James W. Hicks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH: October 16 1878
(Month) (Day) (Year)

7. AGE: 36 yrs. 11 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ky Co Ky

10. NAME OF FATHER: Elijah J Hicks

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Rebecca J Haworth

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Frank Hicks
(Address): Rathdrum Ida Co

15. Filed Nov 10 1916 D. D. Drennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October 8th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1916, to Oct 8 1916, that I last saw h~~im~~ alive on Oct 7 1916, and that death occurred on the date stated above, at 5 pm.

The CAUSE OF DEATH* was as follows:
Sarcoma of liver

(Duration) about yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank Vern M. D.

10/9 1916 (Address) Rathdrum Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Ida — DATE OF BURIAL: Oct 11 1916

20. UNDERTAKER: Dixon Bros — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2110
(No. ..... St.)

File No. 16100
Registered No. 114

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm James Burgess.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Feb (Month) 21 (Day) 1897 (Year)
7. AGE: 9 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Ida —
10. NAME OF FATHER: Geo. Burgess.
11. BIRTHPLACE OF FATHER (State or Country): Ken —
12. MAIDEN NAME OF MOTHER: Ida Keller.
13. BIRTHPLACE OF MOTHER (State or Country): — — —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. Burgess.
(Address) Rigby Ida R.F.D. 3.
15. Filed Sept 12 1916 Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 21 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 25 1916, to Aug 21 1916, that I last saw h.m alive on Aug 21 1916, and that death occured on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:
Pneumonia Infections
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S.S. Fuller M. D.
19..... (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rigby Idaho — — —	Aug 23 1916
20. UNDERTAKER	ADDRESS
W.R. Judd	Idaho Falls.

FORM V. [redacted] 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16101

Registered No. 113

Registration District No. 73

Primary Registration District No. 2112

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

(No. Idaho Falls General Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thos. Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ?

6. DATE OF BIRTH. ? (Month) ? (Day) ? (Year)

7. AGE: about 46 yrs ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Sheep herder

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): ?

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E E Dunwoody

(Address) Idaho Falls

15. Filed 12/2 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 10 1916, to Nov 17 1916, that I last saw h[redacted] alive on Nov 17 1916, and that death occured on the date stated above, at 8a M.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [redacted] M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 11/21 1916

20. UNDERTAKER: E E Dunwoody — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16102

Registered No. 112

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

Registration District No. 13

Primary Registration District No. 2102

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sophia Ely

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH.

March (Month) 27 (Day) 1851 (Year)

7. AGE

64 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... at Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER ? Holmberg

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C E Dunwoody

(Address) Idaho Falls

15.

Filed Nov 26 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1916, to Nov 25 1916, that I last saw her alive on Nov 25 1916, and that death occured on the date stated above, at 4 9 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	11/28 1916
20. UNDERTAKER	**ADDRESS**
C E Dunwoody	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BKRS. 24658

Dr Cline.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 73

Primary Registration District No. 2 1 0 2

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16103

Registered No. 111

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls,

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jerry McGahan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. (Month) 21 (Day) 1866 (Year)

7. AGE: 50 Yrs. 1 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bellemany Ireland

10. NAME OF FATHER: Daniel

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Sarah Montague

13. BIRTHPLACE OF MOTHER (State or Country): Payson Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bernard McGahan

(Address)

15. Filed 12/2 1916 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1916, to Nov 28 1916, that I last saw h[illegible] alive on Nov 28 1916 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary) General Peritonitis

(Duration Yrs. mos. 5 ds.

(Signed) [illegible] M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible] DATE OF BURIAL: Nov 30 1916

20. UNDERTAKER: S. H. Hunt ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHY
ould state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statem
of OCCUPATION is very important. See instructions on back of certificate.

City of Idaho Falls (No. ..... St.) Registered No. 110

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennie Esther Butler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 7 (Day) 1881 (Year)

7. AGE: 25 Yrs. 8 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... at Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Colorado

10. NAME OF FATHER Geo. H. Beckley

11. BIRTHPLACE OF FATHER (State or Country) United States

12. MAIDEN NAME OF MOTHER Martha J Hart

13. BIRTHPLACE OF MOTHER (State or Country) United States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. W. Butler

(Address) Idaho Falls Ida

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21 1916, to Nov 26 1916, that I last saw her alive on Nov 21 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) C. S. Fuller M. D.

19..... (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence ..... Shoshone

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL

Idaho Falls 24 1916

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 73

Primary Registration District No. 2100

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16105

Registered No. 109

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls (No. Fuller Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melvin Ellis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) [illegible] (Day) 1899 (Year)

7. AGE ....Yrs....Mos....ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John H. Ellis

11. BIRTHPLACE OF FATHER (State or Country): Africa

12. MAIDEN NAME OF MOTHER: Nettie Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Wilson Ellis

(Address) Rigby, Ida. R.D. 2.

15.

Filed 12/1 1916 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 1916, to Nov 19 1916, that I last saw h[illegible] alive on Nov 19 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Acute suppurative appendicitis - followed by general peritonitis

(Duration) ....Yrs. ....mos. 11 ....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Nov 24/1916 (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence [illegible]

19. PLACE OF BURIAL OR REMOVAL: Prospect - Via Rigby Ida

DATE OF BURIAL: 11/20 1916

20. UNDERTAKER: C. C. Dinwoody

ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BOOK. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 73

Primary Registration District No. 21 0-0

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16106

Registered No. 104

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

(No. 237 Water ave St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Levi N. Myers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. July 17 1884
(Month) (Day) (Year)

7. AGE 32 Yrs. 4 Mos. ~~11~~ ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) San Emore Wash

10. NAME OF FATHER Charles Myers

11. BIRTHPLACE OF FATHER (State or Country) Mass

12. MAIDEN NAME OF MOTHER Jane Nicholson

13. BIRTHPLACE OF MOTHER (State or Country) California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. W. Myers
(Address) Idaho Falls Idaho

15. Filed Dec. 1 1916 Chas Fennell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. 21 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1916, to Nov 21 1916, that I last saw him alive on Nov 21 1916, and that death occured on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:
Empyema

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary)

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) Dr. S. Fuller M. D.

19.... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Idaho

DATE OF BURIAL: 11/26 1916

20. UNDERTAKER: E. E. Dennoodey

ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BKRS. 24658

Dr Fuller

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 73

Primary Registration District No. 2102

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16107

Registered No. 107

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chris Cramer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. June 21 1[illegible]
(Month) (Day) (Year)

7. AGE 72 Yrs. 5 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Peter Cramer

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alfred Cramer
(Address) City

15.
Filed May 16 1916
Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1916, to Nov 15 1916, that I last saw him alive on Nov 8 1916, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 6 Yrs. mos. ds.

Contributory (Secondary) Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. ds.

(Signed) C. Collins M. D.

Nov 16th 16 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iron Idaho — DATE OF BURIAL: Nov. 17 1916

20. UNDERTAKER: G. H. Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 13
Primary Registration District No. 2107
File No. 16108
Registered No. 106

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eva F Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 24 (Day) 1869 (Year)

7. AGE: 48 Yrs. 5 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: L. S. Willetts

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: Martha Menefee

13. BIRTHPLACE OF MOTHER (State or Country): Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. F. Brown
(Address) Idaho Falls

15. Filed Oct 19 1916 J. E. Bassett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1916, to Oct 18 1916, that I last saw her alive on Oct 18 1916, and that death occured on the date stated above, at 2:50 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Pneumonia

(Duration) Yrs. 0 mos. 10 ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. E. Allen M. D.

Oct 18 1916 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ross Hill — DATE OF BURIAL: Oct 20 1916

20. UNDERTAKER: G. H. Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - VITAL STA., PUBL. & DOC. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2150
(No. ..... St.)

File No. 16109
Registered No. 105

1. PLACE OF DEATH.
County of Bonneville
City of Ucon

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arlen Bybee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Sept. 23 (Month) (Day) 1916 (Year)
7. AGE: ..... Yrs. 26 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Ray Bybee
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Mary Thompson
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David Bybee
(Address) Ucon
15. Filed Oct 21 1916 .....
Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1916, to Oct 18 1916, that I last saw him alive on Oct 18 1916, and that death occured on the date stated above, at 7:50 A.M.

The CAUSE OF DEATH* was as follows:

Acute indigestion

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cerebral Convulsions

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray Starke M. D.
Oct 19 1916 (Address) Ucon Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ucon Idaho — DATE OF BURIAL: Oct 21 1916

20. UNDERTAKER: G. H. Hunt — ADDRESS: Idaho, State

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

(No. ....., ... St.)

Registration District No. 73

Primary Registration District No. 21-0

File No. 16110

Registered No. 104

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jane Dougan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Dec. (Month) 5 (Day) 1826 (Year)

7. AGE: 90 Yrs. 10 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Stone

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J C Dodd

(Address) Idaho Falls

15.

Filed ..... 191..... Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1916, to Oct 24 1916, that I last saw her alive on Oct 23rd 1916, and that death occured on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... Yrs. ..... mos. ..... ds.

(Signed) T. Hollister, M. D.

19..... (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: Buried 1916

20. UNDERTAKER: G H Hunt — ADDRESS: Idaho F

FORM V. S. No. 5-16 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16111

Registered No. 1 6 1

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2 1 0

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harvey L. Mathews

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan. (Month) 1 (Day) 1860 (Year)

7. AGE: 30 Yrs. 9 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Harvey Mathews

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Mary Davis

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. D. Rogers

(Address) Idaho Falls

15. Filed ..... 191.... .....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1916, to Oct. 19 1916, that I last saw h— alive on Oct 19 1916, and that death occured on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Septicaemia following Suppurative Cholecystitis.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) W. D. Rogers M. D.

19..... (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho

DATE OF BURIAL: Oct 19 1916

20. UNDERTAKER: G. H. Hunt

ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. Age should be stated in YEARS, MONTHS and DAYS. EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—PRESS IN A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16112

Registered No. 102

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2 1 0 7

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Fenton Edwards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 29 (Day) 16 (Year)

7. AGE: X Yrs. X Mos. X ds. IF LESS than 1 day how many 15 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls Ida

10. NAME OF FATHER: Geo Q Edwards

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Emma D Williams

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Idaho Falls

15. Filed 12/1 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Still Birth
6 Mo.
Premature - 6 mo.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. S. Fuller M. D.

12/1 1916 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emery-Via Price Utah | DATE OF BURIAL: 12/1 1916

20. UNDERTAKER: [signature] | ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16113

Registered No. 101

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls Ida

(No. Fuller Hosp. St.)

Registration District No. 73

Primary Registration District No. 210-6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H. Nunn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 5 (Day) 1853 (Year)

7. AGE: 63 Yrs. 1 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Va

10. NAME OF FATHER: Elbert H Nunn

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: Mary Zeigler

13. BIRTHPLACE OF MOTHER (State or Country): Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elbert H Nunn

(Address) Idaho Falls

15. Filed Nov 18 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1916, to Nov 17 1916 that I last saw h— alive on Nov 17 1916, and that death occured on the date stated above, at 10P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C S Fuller M. D.

11/11 1916 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence: Shoppen

19. PLACE OF BURIAL OR REMOVAL: Bridgeport - Neb — DATE OF BURIAL: 11/18 1916

20. UNDERTAKER: C E Dunwoody — ADDRESS: Idaho Falls

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. 16114
Registered No. 48

1. PLACE OF DEATH.
County of Franklin
City of Preston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chloe Daniels

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 18 (Day) 1916 (Year)

7. AGE: Yrs. 18 Mos. ..... da. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Preston Idaho

10. NAME OF FATHER Clem P. Daniels

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Chloe Vanorian Daines

13. BIRTHPLACE OF MOTHER (State or Country) Arizona

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs W. Daines
(Address) Preston Ida

15.
Filed ..... 191....
Dr A R Cutler
Local Registrar

SYMS - YORK CO., PTRS. & BKBS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1916 to Nov 30 1916, that I last saw h.. alive on Nov 30 1916, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Exhaustion Exhaustion

(Duration) 1 Yrs. ..... mos. 15 ds.
Contributory (Secondary) Premature

(Duration ..... yrs. ..... mos. 15 ds.
(Signed) A R Cutler M. D.
19.... (Address) Preston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Franklin
DATE OF BURIAL: Dec 2 1916

20. UNDERTAKER: None
ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 16115
Registered No. 43

1. PLACE OF DEATH.
County of Franklin
City of Preston
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sylvia Ann Carling Clark

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 4 (Day) 1895 (Year)

7. AGE: 21 Yrs. 2 Mos. 24 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ogdenville Utah

10. NAME OF FATHER: John Carling

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Lovell

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Ernest Clark
(Address): Preston

15.
Filed Dec 1st 1916 Drake Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1916, to Nov 30 1916, that I last saw h w alive on Nov 30, 1916, and that death occured on the date stated above, at 3:50 P.M.

The CAUSE OF DEATH* was as follows:
Puerpural Eclampsia

(Duration) 0 Yrs. 0 mos. 18 hrs da.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Blank M. D.
12-1-1916 (Address) Preston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho — DATE OF BURIAL: Dec 3 1916

20. UNDERTAKER: W. A. Gledhill — ADDRESS: Preston

SVMS - YORK CO., PTRS. & SONS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16116

Registered No. 47

1. PLACE OF DEATH.

County of Franklin

City of Fairview

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Calysta Ward Warrick Strickland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. February (Month) 15 (Day) 1844 (Year)

7. AGE: Yrs. 72 Mos. 9 ds. 22

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Kemper Co Miss.

10. NAME OF FATHER: Thomas Warrick

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Louisa Darlington Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Darlington Dist. South Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Helen S. Egbert.
(Address) Preston R. F. D. # 3

15.
Filed Dec 16 1916 D. A. Cutler
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
December (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1916 to December 1916, that I last saw her alive on Dec 2 1916, and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of breast

(Duration) 1 Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. B. Magnuson Jr M. D.

19.... (Address) Lewiston [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 42 yrs. 7 mos. days. In the State 42 yrs. 7 mos. days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairview — DATE OF BURIAL: Dec 10 1916

20. UNDERTAKER: none — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-35 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16117

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Franklin

City of Fairview Ward

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Romona Julia McWhorter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Famine

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Singles

6. DATE OF BIRTH.

June 8 (Month) Thursday (Day) 1916 (Year)

7. AGE

.....Yrs. 5 Mos. 7 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE

Fairview Idaho
Franklin Co.
(State or Country)

10. NAME OF FATHER: Fay McWhorter

11. BIRTHPLACE OF FATHER

New York State
(State or Country)

12. MAIDEN NAME OF MOTHER: Julia Cafferty

13. BIRTHPLACE OF MOTHER

Fairview Idaho
Franklin Co.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia McWhorter

(Address) R.F.D. No 3 Box 87 Preston

15.

Filed Dec 1st 1916 Dora Butts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1916, to Nov 15, 1916, that I last saw h[illegible] alive on Nov. 15, 1916, and that death occured on the date stated above, at 1:30 A M.

The CAUSE OF DEATH* was as follows:

Pneumonia-Lobar

.....(Duration) — Yrs. 1 mos. 8 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Blank M. D.

11/17/16 (Address) Preston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairview

DATE OF BURIAL: .....191.

20. UNDERTAKER: None

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BOOK. 24068

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16118

Registered No. 45

1. PLACE OF DEATH.

County of Franklin

City of Preston

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ann Larsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 7 (Day) 1916 (Year)

7. AGE ..— Yrs. ..— Mos. 24 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... —

(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9. BIRTHPLACE (State or Country) Preston Idaho

10. NAME OF FATHER Jacob N. Larsen

11. BIRTHPLACE OF FATHER (State or Country) Paradise Utah

12. MAIDEN NAME OF MOTHER Ellen Bickmore

13. BIRTHPLACE OF MOTHER (State or Country) Paradise Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen Larsen

(Address) .....

15.

Filed Dec 2 1916 Dr A Ruelle Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1916, to Dec 1 1916, that I last saw h— alive on Dec 1st 1916, and that death occured on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions
associated with influenza

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A Ruelle M. D.

19.... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho — DATE OF BURIAL: Dec 3 1916

20. UNDERTAKER: W A Skidmore — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-15 M. 1-15-15

1619

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 197

Primary Registration District No. 2149

File No. 1619

County of Oneida

City of Preston (No. ..... St.)

Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Drusilla Walker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Nov. (Month) 20 (Day) 1 (Year)

7. AGE: 59 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Dressmaker & nurse

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Richmond Utah

10. NAME OF FATHER: W. I. Vancy

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: Catharine Hendricks

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rebecca Walker

(Address) .....

15.

Filed Dec 3 1916 Drake Dueter Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: DEC. (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1916, to Dec 2, 1916, that I last saw h.r alive on ....., 1916, and that death occured on the date stated above, at 1:00 M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....

.....

.....(Duration) 0 Yrs. 0 mos. 3 da.

Contributory (Secondary) Arteriosclerosis

.....(Duration ..... yrs. ..... mos. ..... da.

(Signed) Curtis Blanchard M. D.

12/5/1916 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho | DATE OF BURIAL: Dec.

20. UNDERTAKER: W. W. Steidmore | ADDRESS: Pres

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16120

Registered No. 151

1. PLACE OF DEATH.

County of Cassia

City of Burley.

Registration District No. 167

Primary Registration District No. 2196

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melvin Lowery Mallory.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov 21 (Month) (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 21 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... At home.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Burley Ida.

10. NAME OF FATHER Elmer C. Mallory.

11. BIRTHPLACE OF FATHER (State or Country) Uinta Co. Wyoming.

12. MAIDEN NAME OF MOTHER Ora Braswell,

13. BIRTHPLACE OF MOTHER (State or Country) Old Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmer C. Mallory

(Address) Burley Ida

15.

Filed Nov. 23d 1916 Chas. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21 1916, to Nov 22 1916, that I last saw him alive on Nov 22 1916, and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) W. J. Storey M. D.

19.... (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: View Ida. DATE OF BURIAL: 11/23/1916

20. UNDERTAKER: L. C. Harris. ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 167
Primary Registration District No. 2 1 9 6
File No. 16121
Registered No. 150

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME LeRoy Leonard Howard.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Strike out all but the word.): Single
6. DATE OF BIRTH. Nov. (Month) 18 (Day) 1916. (Year)
7. AGE ..... Yrs. ..... Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: At home.
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country) Burley Ida.
10. NAME OF FATHER John F. Francis Howard.
11. BIRTHPLACE OF FATHER (State or Country) Chicago Ill.
12. MAIDEN NAME OF MOTHER Leona Senn.
13. BIRTHPLACE OF MOTHER (State or Country) Payson Utah.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. F. Howard
(Address) Burley. Idaho.
15.
Filed Nov 27th 1916 Dr. J. C. Patterson Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
11 (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18' 1916, to Nov 26 1916, that I last saw him alive on Nov 25 1916, and that death occured on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:
Duanition
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Prematurity (Mo.)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. J. Storey M. D.
19 ..... (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: 11/27/1916

20. UNDERTAKER: L. B. Falconer ADDRESS: Burley Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16122
Registered No. 152

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ..... St.)

2. FULL NAME Floyd Elmer Martindale

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 5 (Day) 1914 (Year)

7. AGE: 2 Yrs. 8 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Oakley Idaho

10. NAME OF FATHER Elmer A. Martindale

11. BIRTHPLACE OF FATHER (State or Country) Oakley Idaho

12. MAIDEN NAME OF MOTHER Maude Cross

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elmer A Martindale
(Address) Burley Ida

15.
Filed Dec 1st 1916. Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1916, to Nov 30 1916, that I last saw h[illegible] alive on Nov 30 1916, and that death occured on the date stated above, at 11.45 A.M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
renal uremia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. C. Patterson M. D.
12-1 1916 (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley
DATE OF BURIAL: 12/2 1916

20. UNDERTAKER: R. N. Pratt
ADDRESS: Burley

SYMS - YORK CO., PTRS. & BNDS. 24653

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH. 39

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. 2156.
File No. 16124
Registered No. ____

1. PLACE OF DEATH.
County of Boundary
City of Naples
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leslie Monroe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct. (Month) 22 (Day) 1916 (Year)

7. AGE: ____ Yrs. ____ Mos. 13 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: John Allen Monroe

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Mae Browning

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. A. Monroe
(Address) Naples, Ida.

15. Filed Nov. 4 1916. E. E. Fry Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 4th. (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 191__, to ____ 191__, that I last saw h__ alive on ____ 191__, and that death occured on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Unknown —

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) E. E. Fry M. D.

11/4 1916. (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: McArthur, Ida. DATE OF BURIAL: Nov. 5 1916.

20. UNDERTAKER: J. A. Monroe ADDRESS: Naples, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 1-15 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79.
Primary Registration District No. 2156.
File No. 16125
Registered No. .....

1. PLACE OF DEATH
County of Bannock
City of Pocatello (or Village or Township) ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lea Alvin Debring

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1892 (Year)

7. AGE 24 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Lineman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kalispell Mont.

10. NAME OF FATHER John Debring

11. BIRTHPLACE OF FATHER (State or Country) Ontario Canada

12. MAIDEN NAME OF MOTHER Margaret Dean

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Walter Debring
(Address) Bellingham Wash

15. Filed Nov. 4 1916. E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 3rd 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Fracture of Skull
(Hit by train)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) E E Fry M. D.
11/4 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello Idaho	11/8 1916
20. UNDERTAKER	ADDRESS
John J. Mace	Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STNRS. 24056

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16126
Registered No.

1. PLACE OF DEATH.
County of Boundary
City of Bonners Ferry (No. ..... St.)
Registration District No. 79
Primary Registration District No. 2156
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Arthur Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: April (Month) 19 (Day) 1830 (Year)

7. AGE: 86 yrs. 7 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Davis

11. BIRTHPLACE OF FATHER (State or Country): — —

12. MAIDEN NAME OF MOTHER: — — —

13. BIRTHPLACE OF MOTHER (State or Country): — — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Dignan
(Address) 1735 Meagher Ave

15. Filed 12/11/ 1916. Butte, Mont. E. E. Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 9th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191.., to — 191..., that I last saw him alive on Dec 8 1916, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis

(Duration) — yrs. — mos. — ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) C. T. Fawcett M. D.
12-11 1916 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: 12/10 1916
20. UNDERTAKER: John J. Moore — ADDRESS: Bonners Ferry Ida

CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16127
Registered No.

1. PLACE OF DEATH.
County of Boundary
City of Copeland
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79
Primary Registration District No. 515-6.
(No. ....., ... St.)

2. FULL NAME Victoire Russell.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.

6. DATE OF BIRTH: Dec. (Month) 23rd. (Day) 1851 (Year)

7. AGE: 64 yrs. 11 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): France -

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): France.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Jean Jeffries
(Address)

15. Filed Dec. 4th 1916. E. E. Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 3rd. (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Apoplexy.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Fry M. D.
12/4 1916 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Copeland, Ida. DATE OF BURIAL: Dec. 5th 1916.

20. UNDERTAKER: John T. Moore ADDRESS: Bonners Ferry.

CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 24

Primary Registration District No. 2156

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16128

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Boundary

City of Bonners Ferry (No.) ..... (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andreas Skaug

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. May (Month) 8 (Day) 1832 (Year)

7. AGE: 84 Yrs. 6 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Lars Skaug

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Lisa Hafren

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Caesary

(Address) Bonners Ferry Idaho

15.

Filed ..... 191....

E. E. Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191....., to ..... 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Unknown

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration 4 Yrs. 4 mos. — ds.

(Signed) E. E. Fry M. D.

..... 19.... (Address) Bonners Ferry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida

DATE OF BURIAL: 11/22 191 6

20. UNDERTAKER: John T. Mase

ADDRESS: Bonners Ferry Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16129
Registered No. .....

1. PLACE OF DEATH.
Registration District No. 79.
Primary Registration District No. 3156.
County of Canyon
City of Bonners Ferry (or St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pvt. Dimiad Dunn
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 42 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Boiler Maker
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rochester N.Y.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jodie Dutton
(Address) Aurora Illinois

15. Filed Nov. 17-1916. E. E. Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 16th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 8.30 P. M.
The CAUSE OF DEATH* was as follows:
Pleuro-Pneumonia-
(Post Mortem)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) E. E. Fry M. D.
11/17 1916 (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida. DATE OF BURIAL: 11/20 1916

20. UNDERTAKER: John J. Mace ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 16130
Registered No. 64

1. PLACE OF DEATH.
County of Bingham
City of Roy.
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Wood

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)
7. AGE ..... Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Utah
10. NAME OF FATHER: Geo. Gunnel
11. BIRTHPLACE OF FATHER (State or Country): America
12. MAIDEN NAME OF MOTHER: Genette Hill
13. BIRTHPLACE OF MOTHER (State or Country): America
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Joseph Wood
(Address): Burton
15. Filed 11/11 1916 — G. L. Estes, Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 9 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 11/5 1916, to 11/9 1916, that I last saw her alive on 11/9 1916, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Mitral Stenosis
(Duration) Many Yrs. mos. ds.
Contributory (Secondary) Ch. relapsing Nephritis
(Duration) Many yrs. mos. ds.
(Signed) Joseph Wacker M. D.
19.... (Address) Roy Burg. Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL: 11/12 1916
20. UNDERTAKER: John K. Phillips — ADDRESS: Roy

FORM V. S. No. 6-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 2178
File No. 16131
Registered No. 65

1. PLACE OF DEATH.
County of Madison
City of Independence (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosannah Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. ..... (Month) ..... (Day) 1869 (Year)
7. AGE: 47 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): America
10. NAME OF FATHER: Charles Gallaway
11. BIRTHPLACE OF FATHER (State or Country): America
12. MAIDEN NAME OF MOTHER: Miss Cutler
13. BIRTHPLACE OF MOTHER (State or Country): America
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Frank D. Smith
(Address): Thornton
15. Filed 11-13 1916 — G.L. Espe, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 12 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 10 P M.
The CAUSE OF DEATH* was as follows:
Unknown: Probably acute dilitation of heart.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G.L. Espe M. D.
19.... (Address) .....

*State the DISEASES CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL: 11/14 1916
20. UNDERTAKER: John Phillips — ADDRESS: Replume

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FVIBB - YORK CO., PTRS. & BOOK. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16132
Registered No. 66

1. PLACE OF DEATH.
County of Madison
City of Rex.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ramer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb. (Month) 17 (Day) 1909 (Year)

7. AGE: 7 Yrs. 9 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Nebraska

10. NAME OF FATHER Phillip Ramer

11. BIRTHPLACE OF FATHER (State or Country) Europe

12. MAIDEN NAME OF MOTHER Mary

13. BIRTHPLACE OF MOTHER (State or Country) Europe

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Philip Ramer
(Address) Rexburg.

15. Filed NOV 17 1916 191.....
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
11 (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-12 1916, to 11-15 1916, that I last saw h[illegible] alive on 11-13 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral abscess

.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) .....
.....(Duration) .....Yrs.....mos.....ds.
(Signed) G. H. Espe M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar City | DATE OF BURIAL: 11/18 1916

20. UNDERTAKER: John Phillips | ADDRESS: Rex.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 16133
Registered No. 67

1. PLACE OF DEATH.
County of Bear Lake
City of Logan
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Jane Mare

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec (Month) 22 (Day) 1880 (Year)

7. AGE, 35 Yrs. 10 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: John L. Roberts

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Elizabeth Ann Dredge

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Elizabeth Roberts
(Address) Logan Utah

15. Filed NOV 17 1916 191 .....
G G Espe
Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
11 (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Toxaemia of Pregnancy
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J R Stumpe M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sugar	11/19/1916
20. UNDERTAKER	ADDRESS
John Phillips	Replume

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ..... , ... St.)

File No. 16134
Registered No. 68

1. PLACE OF DEATH.
County of Fremont
City of Chester
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ternent Isaac Evans

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Oct. (Month) 12 (Day) 1873 (Year)

7. AGE: 43 Yrs. 1 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm Evans

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Nancy Goodrum

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Evans
(Address) Utah

15. Filed NOV 21 1916 191....
G H Espe
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-6- 1916, to 10-20 1916, that I last saw him alive on 10-20 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Aortic & Mitral regurgitation

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) G H Espe M. D.
19.... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton
DATE OF BURIAL: 11/21 1916

20. UNDERTAKER: John Hill Jr.
ADDRESS: Redrune

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 16135
Registered No. 69

1. PLACE OF DEATH.
County of Ada.
City of Plano
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clark H. Jackson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Nov. (Month) 17 (Day) 1883 (Year)

7. AGE: 33 Yrs. ..... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: J. C. Jackson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lettie A. Hawley

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. C. Jackson
(Address) Plano

15. Filed 11-22 1916
G. G. Estes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
11 (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-21 1916, to 11-21 1916, that I last saw h~~im~~ alive on 11-21 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
suicidal gunshot in head

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. G. Estes M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parker — DATE OF BURIAL: 11/23 1916

20. UNDERTAKER: John Phillips — ADDRESS: Rex

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-2b M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16136
Registered No. 71

1. PLACE OF DEATH.
County of Madison
City of Sugar R.F.D.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178

2. FULL NAME Wayne McKinley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Nov (Month) 12 (Day) 1916 (Year)
7. AGE ..... Yrs. ..... Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Sugar Ida
10. NAME OF FATHER Wm B. McKinley
11. BIRTHPLACE OF FATHER (State or Country) Ida
12. MAIDEN NAME OF MOTHER Florence Packham
13. BIRTHPLACE OF MOTHER (State or Country) Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A Mortfield
(Address) Stanleyonly Ida
15. Filed 12/2 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 30 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1916, to Nov 30 1916, that I last saw him alive on Nov 28 1916, and that death occured on the date stated above, at 10a M.
The CAUSE OF DEATH* was as follows:
Non development, a premature birth at 7 mos.
..... (Duration) ..... Yrs. ..... mos. 18 ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) A Mortfield M. D.
19..... (Address) Stanleyonly

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Teton
DATE OF BURIAL: Dec 1 1916
20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

County of Fremont

Primary Registration District No. 2178

File No. 16137

City of ..... (No. ....., ... St.)

Registered No. 71

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Birda Kemp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Jan (Month) 28 (Day) 1892 (Year)

7. AGE: 27 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Y. Le. Bowles

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Francis Royston

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Y. Le. Bowles

(Address) Ryburn

15. Filed 12/14 1916 G. G. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr Jones M. D.

19.... (Address) Sudan

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ryburn — DATE OF BURIAL: 12/5 1916

20. UNDERTAKER: John Phillips — ADDRESS: Ryburn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. .... St.)

File No. 16138
Registered No. 72

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Oct. (Month) 17 (Day) 1852 (Year)

7. AGE: 64 Yrs. 1 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labourer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed 12/14 1916 G Gospe Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 3 (Day) 1916 (Year).

17. I HEREBY CERTIFY, That I attended deceased from 12/7, 1916, to 12/13 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 1115 P.M.

The CAUSE OF DEATH* was as follows:
La Grippe
.....
.....
.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary)
.....(Duration .....yrs. .....mos. .....ds.
(Signed) G Gospe M D M. D.
.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL: 12/5 1916

20. UNDERTAKER: John Billings — ADDRESS: Rexburg

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 16189
Registered No. 78

1. PLACE OF DEATH.
County of Jefferson
City of Parker (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lorenzo Farley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH.
Mar. (Month) 25 (Day) 1867 (Year)

7. AGE
49 Yrs. 8 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Canada

10. NAME OF FATHER Winthrop Farley

11. BIRTHPLACE OF FATHER
(State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary Ec Hastings

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Lorenzo Farley
(Address) Parker

15.
Filed DEC 7 1916 191....
G L Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
12 (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Endocarditis of Pulmonary
Tuberculosis of Lungs

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A Mansfield M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parker — DATE OF BURIAL: 12/9 1916

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 108
Primary Registration District No. 2178
File No. 16140
Registered No. 74

1. PLACE OF DEATH.
County of Fremont
City of Teton
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac A Stewart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Aug (Month) 24 (Day) 1847 (Year)

7. AGE: 69 Yrs. 3 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Joseph Clark

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary A. Clark

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Samuel Stewart
(Address) Teton

15. Filed 1/8 1916 G. H. Estes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1916, to Dec 7 1916, that I last saw her alive on Dec 5 1916, and that death occured on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:
Cirrhosis of Liver & obstructed gall Bladder
(Duration) Yrs. 9 mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J Mansfield M. D.
12/9 1916 (Address) Teton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Teton
DATE OF BURIAL 1916

20. UNDERTAKER: H Ryan
ADDRESS Ryan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1611

Registered No. .....

1. PLACE OF DEATH.

County of Teton

City of Victor

Registration District No. 20

Primary Registration District No. 2012

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur Westley Campbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. November 30 1916
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Victor Idaho

10. NAME OF FATHER Arthur Campbell

11. BIRTHPLACE OF FATHER (State or Country) Sandpete Utah

12. MAIDEN NAME OF MOTHER Alice Florence Shelly

13. BIRTHPLACE OF MOTHER (State or Country) Sanpete Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Dec 5 1916 E. D. Meacham
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 4 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Novemb 30 1916, to Dec 4 1916, that I last saw h[illegible] alive on Dec 3 1916, and that death occured on the date stated above, at 1 p. M.

The CAUSE OF DEATH* was as follows:

paralysis of bowels

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Louis Vuthier M. D.

Dec 5 1916 (Address) Victor Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL 191

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24658

FORM V. S. No. 5-35 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16142

Registered No. .....

Registration District No. 118

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Cassia

City of Albion

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wanda Bingham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Baby

6. DATE OF BIRTH. Sept. 6 (Month) (Day) 1916 (Year)

7. AGE: .....Yrs. 2 .....Mos. 2 .....ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sunnydale Ida.

10. NAME OF FATHER Charles C Bingham

11. BIRTHPLACE OF FATHER (State or Country) Teton Basin Ida.

12. MAIDEN NAME OF MOTHER Lillie May Kidd

13. BIRTHPLACE OF MOTHER (State or Country) Colorado.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles C Bingham

(Address) Basin Idaho

15. Filed Dec 19 1916 R T Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1916 to Nov 6 1916, that I last saw h alive on Nov 6 1916, and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Pneumonia

General weakness

(Duration) One wk. two days ds.

Contributory (Secondary) Only saw it once

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R T Greene M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? Visiting in Idaho

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Basin

DATE OF BURIAL: Nov 11th 1916

20. UNDERTAKER: Charles C. Bingham

ADDRESS: Basin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 1-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 8285 — File No. 16144

County of Twin Falls — Township or Village — District No. 8285

City of ..... (No. ....., ... St.) Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Thorson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug. 1 (Month) (Day) ..... (Year)

7. AGE: 39 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Ola Thorson

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: don't know

13. BIRTHPLACE OF MOTHER (State or Country): don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oscar Olsen

(Address) Foreyth Mont

15. Filed 11-17-1916 — John F. Coughlin — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 14 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 3 1916, to Nov. 14 1916, that I last saw h[illegible] alive on Nov 14 1916, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Meningitis (non infective).

..... (Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. [illegible] ds.

(Signed) H. W. Loucheck (Co) M. D.

Nov 17 1916 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Nov. 17 1916

20. UNDERTAKER: Summers & Evans — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16145

1. PLACE OF DEATH.
County of Twin Falls
City of "
Registration District No 37
Primary Registration District No 1095
(No. ....., ... St.)
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Jolla Leichliter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. October (Month) 17 (Day) 1895 (Year)

7. AGE: 21 Yrs. X Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: R. B. Jones

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. B. Leichliter
(Address) R. 2. Box 3 Twin Falls Ida

15. Filed 11-10 1916. John W. Hearnsberger Local Registrar

SYMS-YORK CO., PTRS. & ADVT. 24958

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1916, to Nov 8 1916, that I last saw h.er alive on Nov 8 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary): Pyosalpinx

(Duration 2 yrs. ..... mos. ..... ds.

(Signed) Chas. P. Leath M. D.

19..... (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 11-10 1916

20. UNDERTAKER: C. J. Crosby — ADDRESS: T. F.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 16146
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laurence Garner

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. December 14 1897
(Month) (Day) (Year)

7. AGE: 18 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: E. H. Garner

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Carrie Olson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed 11 - 6 1916 John F. Coughlin Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
11 (Month) - 6 (Day) - 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27th 1916, to Nov 6 1916, that I last saw him alive on Nov 6th 1916, and that death occured on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:
Septicaemia

(Duration) ..... Yrs. ..... mos. 35 ds.
Contributory (Secondary) Shock
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. E. Leerburg M. D.
19..... (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? Shoshone, Ida.
Former or usual residence Shoshone Ida

19. PLACE OF BURIAL OR REMOVAL: Shoshone Ida
DATE OF BURIAL: Nov 6 1916

20. UNDERTAKER: C. Crosby
ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16148

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

2. FULL NAME Andrew Straite

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. (Month) 13 (Day) 1916 (Year)

7. AGE: Yrs. 2 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Montana

10. NAME OF FATHER Charlie Straite

11. BIRTHPLACE OF FATHER (State or Country) Kan

12. MAIDEN NAME OF MOTHER Minnie McKinney

13. BIRTHPLACE OF MOTHER (State or Country) Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charlie Straite
(Address) Twin Falls Ida

15. Filed 11-16- 1916 John T. Coughlin Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw it alive on ..... 191...,
and that death occured on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Diarrhoea Enteritis

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Weaver M. D.
19... (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Nov. 16 1916

20. UNDERTAKER: Sorensen & Evans — ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)

File No. 16150
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel L. Knapp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Nov (Month) 8 (Day) 1916 (Year)

7. AGE — Yrs. — Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Twin Falls Ida.

10. NAME OF FATHER S. L. Knapp.

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Mabel Randall.

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S. L. Knapp.
(Address) 403 - 3d West, Ogden.

15. Filed 11 - 22 1916 John F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) - 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17 1916, to Nov 21 1916, that I last saw him alive on Nov 21 1916, and that death occured on the date stated above, at 12 Noon.

The CAUSE OF DEATH* was as follows:
Atelectasis
(Duration) ..... Yrs. ..... mos. 22 ds.
Contributory (Secondary) Uraemia
(Duration ..... yrs. ..... mos. 2 ds.

(Signed) M. E. Learbier M. D.
19 ..... (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho. DATE OF BURIAL: Nov 23 1916

20. UNDERTAKER: Grossman & Ennis. ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16151

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 1185

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy W. Lincoln

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 15 (Day) 1896 (Year)

7. AGE: 20 Yrs. 8 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo. A. Lincoln

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Anna Jackson

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George A. Lincoln
(Address) Twin Falls R.F.D.1.

15. Filed 11-29. 1916 John T. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8th 1916, to Nov 23d 1916, that I last saw him alive on 11/21 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
(Meningitis Probably Tubercular)

(Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Pk M. D.
11/29/16 (Address) Twin Falls Ida.

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls. DATE OF BURIAL: Nov 24 1916

20. UNDERTAKER: Grossman & Ennes. ADDRESS: Twin Falls. Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1065
File No. 16152
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martin Martinez

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Unknown

6. DATE OF BIRTH. Unknown
(Month) (Day) (Year)

7. AGE: About 40 Yrs. ..... Mos. ..... Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Restaurant Cook
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Loyd Reynolds
(Address) Rogerson Ida.

15. Filed 12-2- 1916 John F Coughlin Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11-28 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows:

Shock from a burn

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

Duration ..... Yrs. ..... mos. ..... ds.

(Signed) Chas Crosby M. D.
19..... (Address) Twin Falls Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 11-29 1916

20. UNDERTAKER: Chas Crosby — ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16153

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of (1) (1)

Registration District No. 37

Primary Registration District No. 1695

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alma Milligan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 9 (Day) 1876 (Year)

7. AGE: 40 Yrs. 5 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER George Strode

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Sarah J. Riner

13. BIRTHPLACE OF MOTHER (State or Country) Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marion Milligan

(Address) Twin Falls Ida

15. Filed 12-4 1916 John F. Coughlin Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1916, to Nov 29 1916, that I last saw her alive on Nov 29 1916, and that death occured on the date stated above, at [illegible] P. M.

The CAUSE OF DEATH* was as follows:

Purulent pleurisy

(Duration) Yrs. 2 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. Worden M. D.

Nov 29 1916. (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Grossman & Evans ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 1050

File No. 7 16154

County of Kootenai

City of Coeur d'Alene (No. ....., ... St.)

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frederick Shallis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	Married

6. DATE OF BIRTH. (Month) (Day) (Year) 1867

7. AGE 47 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New Hampshire

10. NAME OF FATHER Joseph

11. BIRTHPLACE OF FATHER (State or Country) New Hampshire

12. MAIDEN NAME OF MOTHER Clara Perkins

13. BIRTHPLACE OF MOTHER (State or Country) New Hampshire

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Shallis

(Address) .....

15. Filed Dec-11 1916 A. Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 1916, to Dec. 10 1916, that I last saw him alive on Dec. 9 1916, and that death occured on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows;

Endocarditis

(Duration) 1 Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) J. A. Hughes M. D.

Dec. 11 1916 (Address) Coeur d'Alene, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest	Dec 11 1916

20. UNDERTAKER	ADDRESS
S. J. Lucas	C'd'A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRD - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 716155

Registered No. 26

Registration District No. 29

Primary Registration District No. 105

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D'Alene

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion Dollar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Mar. (Month) 29 (Day) 1838 (Year)

7. AGE 78 Yrs. 8 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Scotland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed 12-5 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1916, to Dec 14 1916, that I last saw h[illegible] alive on Dec 14 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. — mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Dwyer M. D.

Dec 15 1916 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Newberry [illegible] DATE OF BURIAL .....191.....

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai — Registration District No. 24 — File No. 16156

City of E W A — Primary Registration District No. 1050 — Registered No. 24

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W Vandenburg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 60 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N. Y

10. NAME OF FATHER: Richard Vandenburg

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: Eliza Strong

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. F. Pritchard

(Address) 1011 Sherman Ave C'd'A

15. Filed 12-14 1916 — A. Hughes, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1916, to Dec 12 1916, that I last saw h.im alive on Dec 11 1916, and that death occured on the date stated above, at 9 9 M.

The CAUSE OF DEATH* was as follows:

Hemorrhage of the stomach due to ulcer

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jno Bunby M. D.

19 ..... (Address) Coeur d'alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest — DATE OF BURIAL: Dec 14 1916

20. UNDERTAKER: S J Penn — ADDRESS: E W A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai — Registration District No. 29 — File No. 16157

City of Coeur d'Alene — Primary Registration District No. 105 — Registered No. 28

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm B McFarland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 49 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): County Officer

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Wm B

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Elvira Early

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R E McFarland

(Address) Coeur d'Alene Idaho

15. Filed Nov - 26 1916 — A Hughes, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1916, to Nov. 25 1916, that I last saw him alive on Nov. 24 1916, and that death occured on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:

Endarteritis Obliterans

..... (Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hayes M. D.

Nov 26 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem	Nov 26 1916
20. UNDERTAKER	**ADDRESS**
S J Lee	C d A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 716158

Registered No. 29

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D'Alene (No. ....., ... St.)

Registration District No. 29

Primary Registration District No. 105

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha E. Meyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 13 (Day) 1916 (Year)

7. AGE ..... Yrs. 1 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Coeur d'Alene

10. NAME OF FATHER Henry Meyer

11. BIRTHPLACE OF FATHER (State or Country) Ind.

12. MAIDEN NAME OF MOTHER Lottie Cowden

13. BIRTHPLACE OF MOTHER (State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Meyer

(Address) .....

15. Filed 11-30-1916 D. F. Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 28 1916, to ..... 191..., that I last saw h[er] alive on Nov 28 1916, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal Infection

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Runyan M. D.

Nov 29 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant View cem. DATE OF BURIAL: Nov 29 191...

20. UNDERTAKER: Cassedy & Nelson ADDRESS: Coeur

BYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1050
File No. 16159
Registered No. 30

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Clay Shearer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH.
July (Month) 29 (Day) 1844 (Year)

7. AGE
72 Yrs. 4 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: John Shearer

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Aseanath Cowan

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. C. Shearer
(Address) .....

15.
Filed Nov. 30 1916
H. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 25 1916, to Nov. 29 1916, that I last saw him alive on Nov. 29 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral embolism.

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Chronic interstitial nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) John D. Wood M. D.
Nov. 29 1916 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetary	Dec. 1 1916
20. UNDERTAKER	ADDRESS
Cassidy Nelson	Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16160
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of Rainbow Mine.
(No. , St.)

Registration District No. 29
Primary Registration District No. 105

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred [redacted] Hanenkrat.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: November (Month) 16 (Day) 1916 (Year)

7. AGE: 20 yrs. 9 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: Henry Hanenkrat

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Alvina Besemann

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lymond Hanenkrat
(Address) Cataldo Ida.

15. Filed Nov 17 1916 A Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191—, to ——— 191—
that I last saw h— alive on ——— 191—
and that death occurred on the date stated above, at —— M.

The CAUSE OF DEATH* was as follows:
Premature blast in a mine
death instantaneous

—— (Duration) — yrs. — mos. — ds.
Contributory
(Secondary)
—— (Duration) — yrs. — mos. — ds.

(Signed) Alexander Cairns M. D.
11-18- 1916 (Address) C. & A. Coroner.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem — DATE OF BURIAL: Nov 20 1916

20. UNDERTAKER: S & Q Mort — ADDRESS: C W A

CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16161

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29

Primary Registration District No. 1050

2. FULL NAME Wm. Dahlin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 1 (Day) 1863 (Year)

7. AGE 53 Yrs. 1 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Gustaf Carlson

11. BIRTHPLACE OF FATHER (State or Country): Sverige

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Dahlin
(Address) .....

15. Filed 12-5 1916 — F. Hughes, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1916, to Dec 3rd 1916, that I last saw him alive on Dec 2nd 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Intercurrent Meningitis K
Complicates

(Duration) 3 Yrs. ✓ mos. ✓ ds.

Contributory (Secondary) Accidental ✗ 3 ago

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Worthington M. D.

12/4 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: DEC 6 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 716162

Registered No. 32

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 105

County of Kootenai

City of Coeur D'Alene (No. ..., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel Johnston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb. (Month) 16 (Day) 1842 (Year)

7. AGE: ....Yrs. 74 Mos. 9 ds. 23

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Johnston

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oleg Anderson

(Address) .....

15. Filed 12-11- 1916

H. Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 5 1916, to Dec. 9 1916, that I last saw him alive on Dec. 8. 1916, and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

.....(Duration) .....Yrs. .....mos. 4 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jno Elwood M. D.

Dec 9 1916 (Address) Coeur d'alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Dec 11 1916

20. UNDERTAKER: Cassedy & Soon — ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16163

Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Palouse

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41

Primary Registration District No. 2116

(No. ..... St.)

2. FULL NAME Leslie John Butt

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. October 30th 1916.
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ...
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9. BIRTHPLACE (State or Country) Palouse Idaho.

10. NAME OF FATHER George E Butt

11. BIRTHPLACE OF FATHER (State or Country) Wyoming

12. MAIDEN NAME OF MOTHER Emma M. Webb

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George E Butt
(Address) Palouse Idaho.

15. Filed Nov. 10 1916 E D Herndon
Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 17th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Failure to Clear from valve

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. S. Wright M. D.

11/20 1916 (Address) Palouse

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Palouse Cemetery — DATE OF BURIAL: 11-19-1916

20. UNDERTAKER: W C Haeber — ADDRESS: Palouse Idaho

Form V. S. No. 5. 12½M.7-24-11

[redacted] of Idaho
[redacted] HEALTH
[redacted] Vital Statistics

1. PLACE OF DEATH. Registration D[redacted] 21 [redacted] 6164

County of Lemhi Primary Registration District No. 21 [redacted]

City of Salmon (No. ....., ... St.) Registered No. 39

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Marion Morgan If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Dec 1st 1916 (Month) (Day) (Year)

7. AGE: 5 yrs. 7 mos. 5 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Walkerville Montana

10. NAME OF FATHER W. J Morgan

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Lana Goodall

13. BIRTHPLACE OF MOTHER (State or Country) Salmon Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R P. Goodall
(Address) Salmon Idaho.

15. Filed Dec 2 1916 E. D Herndon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATH OF DEATH Dec 1st 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from [redacted] to Dec 1st 1916 that I last saw [redacted] on Dec 1st 1916 and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Scarlet fever

..... (Duration) ..... yrs. ..... mos. 20 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F S Wright M. D.

Dec 2 1916 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: W C Haeleler DATE OF BURIAL: Dec 2" 1916

20. UNDERTAKER: Salmon Cemetery ADDRESS: Salmon Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16166
Registered No. 41

1. PLACE OF DEATH.
County of Lemhi
City of Lemhi

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct. (Month) 18 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Lemhi

10. NAME OF FATHER: Robert Franklin

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Wilhelmina Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. F. Hamme
(Address) Salmon

15.
Filed Dec 17 1916 E. D. Herndon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/18/16, to 10/18/16
that I last saw him alive on 10/18/16
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Pneumatic Influ

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Hamme M. D.
10/26/16 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lemhi
DATE OF BURIAL: 10/20/16

20. UNDERTAKER: Neil
ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16167

Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Clearwater

City of Orofino

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90

Primary Registration District No. 7164

(No. ..... St.)

2. FULL NAME Andrew Buschman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Not Known

6. DATE OF BIRTH. (Month) Not Known (Day) 1 (Year)

7. AGE: about 60 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Not Known

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) ?

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A B Carlton

(Address) Orofino Idaho

15. Filed Dec 1 1916

J M Jarvis
Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1914, to Oct 27 1916, that I last saw him alive on Oct 27 1916, and that death occured on the date stated above, at 4.50 P.M.

The CAUSE OF DEATH* was as follows:

Epilepsy.

?

(Duration) ? Yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

(Duration) 2 yrs. 4 mos. 4 ds.

(Signed) John Simms M. D.

Oct 27 1916 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 4 mos. 4 days. In the State ? yrs. ? mos. ? days

Where was disease contracted if not at place of death? ?

Former or usual residence ?

19. PLACE OF BURIAL OR REMOVAL: Sanitarium Cemetery

DATE OF BURIAL: Oct 31 1916

20. UNDERTAKER: P M Johnson

ADDRESS: Orofino, Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16168

Registered No. 49

Registration District No. 90

Primary Registration District No. 3168

(No. ..... St.)

1. PLACE OF DEATH.

County of Clearwater

City of Orofino Ida

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymond O'Rourke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ? (Month) ? (Day) 1899 (Year)

7. AGE: 27 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. T. Blanton

(Address) Orofino

15. Filed Dec 1 1916

J. W. Hasty
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1916, to Nov 8 1916, that I last saw him alive on Nov 7 1916, and that death occured on the date stated above, at 12.40 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary): Insanity

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John D. Simms M. D.

Nov. 8 1916 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 6 yrs. 11 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence: N. D. Coeur d'Alene

19. PLACE OF BURIAL OR REMOVAL: Sanitarium Cemetery

DATE OF BURIAL 191

20. UNDERTAKER: P. M. Johnson

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Elmore
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 95
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 16169
Registered No. 50
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Ruthbun

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Oct 1 (Month) 1 (Day) 1856 (Year)

7. AGE
60 yrs. 1 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Homesteader
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER Thomas Cooper

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Cooper

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. L. D. Pearson
(Address) Leland Ida

15.
Filed Nov 20 1916 J. M. Tinsley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1916, to Nov 19th 1916, that I last saw h[illegible] alive on Nov 19th 1916, and that death occurred on the date stated above, at 11:50 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver and Gall bladder

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Tinsley M. D.
Nov 20 1916 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Orofino Ida	11/24 1916
20. UNDERTAKER	ADDRESS
W. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 40
Primary Registration District No. 2168
File No. 16170
Registered No. 51

1. PLACE OF DEATH.
County of Clearwater
City of Orofino Ida (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dennis Raymond
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH.
— (Month) — (Day) 1885-4 (Year)

7. AGE
62 Yrs. — Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. Lodging house Keeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A Blanton
(Address) Orofino - Idaho

15. Filed Nov 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 1910, to Nov 20 1916, that I last saw him alive on Nov 20 1916, and that death occured on the date stated above, at 5-50 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis.

(Duration) 4 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity.

Jan (Duration 18 yrs. — mos. — ds.
(Signed) John M Johnson M. D.
NOV 2/1916 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. 9 mos. — days. In the State 3 yrs. 1/4 mos. 3/4 days
Where was disease contracted if not at place of death?.....
Former or usual residence N. I. Sanitarium

19. PLACE OF BURIAL OR REMOVAL: N.I. Sanitarium Cemetery. DATE OF BURIAL: 191

20. UNDERTAKER: P. M. Johnson ADDRESS:

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16171
Registered No. 5-2

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2168
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robt D. Goodwin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1874 (Year)

7. AGE: 42 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): ?

10. NAME OF FATHER: Calvin Goodwin

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A B Blanton
(Address) Orofino Ida

15. Filed Dec 1 1916
J M Tait
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1916, to Nov 21 1916, that I last saw him alive on Nov 21 1916, and that death occured on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Epilepsy
..... (Duration) 5 Yrs. 11 mos. 9 ds.
Contributory (Secondary) Insanity
..... (Duration 5 yrs. 11 mos. 9 ds.
(Signed) John Stevens M. D.
Nov 22 1916 (Address) Orofino, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. 11 mos. 9 days. In the State 1 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence N. I. Sanitarium

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida — DATE OF BURIAL: 11/24 1916

20. UNDERTAKER: W. E. Stoddard — ADDRESS: Giffud Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

undertaker

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 40
Primary Registration District No. 2168
File No. 16172
Registered No. 53

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Dillard.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1843 (Year)

7. AGE: 73 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. Blanton
(Address) Orofino, Ida

15. Filed Dec 1 1916
J. M. Finley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1915, to Nov 24 1916, that I last saw h[illegible] alive on Nov 24 1916, and that death occured on the date stated above, at 11.40 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)
(Duration 1 yrs. 1 mos. 17 ds.

(Signed) John Simmons M. D.
Nov 2 1916 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 1 mos 12 days. In the State 1 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence N. I. Sanitarium

19. PLACE OF BURIAL OR REMOVAL: Asylum Sanitarium Cem. DATE OF BURIAL: Nov 27 1916

20. UNDERTAKER: P. M. Johnson ADDRESS: Orofino, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16173

Registered No. 54

1. PLACE OF DEATH.

County of Clearwater

City of Orofino, Ida

Registration District No. 90

Primary Registration District No. 768

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Northrop.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. — (Month) — (Day) 1851 (Year)

7. AGE: 65 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Connecticut

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A B Carlton

(Address) Orofino, Idaho

15. Filed Dec 1 1916

J. M. Finley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1916, to Nov. 25" 1916, that I last saw him alive on Nov 24 1916, and that death occured on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Paraplegia

(Duration) — Yrs. 4 mos. 10 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

Nov. 25 1916. (Signed) John Givens M. D.

(Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. 4 mos. 10 days. In the State 3 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence N. I. Sanitarium

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Post Falls Ida — DATE OF BURIAL: 11/29 1916

20. UNDERTAKER: [illegible] — ADDRESS: Orofino Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & STNRS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 96
County of Clearwater Primary Registration District No. 2168
City of Orofino (No. ..... St.)
File No. 16174
Registered No. 55
If death occurs away from usual residence, give facts called for under special information. If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH Nov 24 1916
(Month) (Day) (Year)

7. AGE ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..6.. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Allen Seales

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Myrtle Mayfield

13. BIRTHPLACE OF MOTHER (State or Country) Okla

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Allen Seales
(Address) Orofino, Ida

15. Filed Nov 25 1916 J M Tracy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 25 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1916, to Nov 24 1916
that I last saw him alive on Nov 24 1916
and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Cremation
6 hr Mo. Uter-Gestation
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) — yrs. 2 mos. ..... ds.

(Signed) J M Tracy M. D.
11/25 1916 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Wheatley Creek Cemetery | DATE OF BURIAL Nov 25 1916

20. UNDERTAKER None | ADDRESS —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 2168
(No. ..... , ... St.)

File No. 16175
Registered No. 56
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Not named

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Nov (Month) 14 (Day) 16 (Year)

7. AGE: ..... yrs. ..... mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jno J. Bell

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Maggie Jeffries

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Mary J. Bell
(Address) Orofino, Ida

15. Filed Nov 26 1916 J. M. Fairley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h— alive on Nov 14 1916, and that death occurred on the date stated above, at —M.

The CAUSE OF DEATH* was as follows:

Not known - No Medical attendance.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) — yrs. — mos. ..... ds.

(Signed) J. M. Fairley M. D.

19.... (Address) Orofino, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino, Ida | DATE OF BURIAL: Nov 26 1916

20. UNDERTAKER: None | ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2196
File No. 16176
Registered No. 31

1. PLACE OF DEATH.
County of Jefferson
City of Rigby
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hilda Burr Mavis

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 31 (Day) 1898 (Year)

7. AGE: 18 yrs. 3 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salem Co, Utah.

10. NAME OF FATHER: Henry Mavis.

11. BIRTHPLACE OF FATHER (State or Country): Salem Co., Utah

12. MAIDEN NAME OF MOTHER: Emmer Coward

13. BIRTHPLACE OF MOTHER (State or Country): Payson. Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Mavis.
(Address) Rigby, Idaho.

15.
Filed Dec 26 1916 Ray H Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Sept. (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 21 1916, to Sept. 23, 1916, that I last saw her alive on Sept. 22 1916, and that death occurred on the ~~date stated~~ Sept 23 above, at 9:15 A M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) yrs. 6 mos. 23 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Harrison Hartwigsen M. D.
1916 (Address) Rigby, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 8 yrs. 5 mos. 17 days. In the State 8 yrs. 5 mos. 19 days.
Where was disease contracted if not at place of death?
Former or usual residence Salem Utah

19. PLACE OF BURIAL OR REMOVAL: Rigby Idaho
DATE OF BURIAL: Sept 26 1916

20. UNDERTAKER: Carson Hatch
ADDRESS: Rigby Ida

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
(No. ..... St.)

File No. 16177
Registered No. 32

1. PLACE OF DEATH.
County of Jefferson
City of Lewisville

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily A. Handwerk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. July (Month) 16 (Day) 1876 (Year)
7. AGE: 40 Yrs. 7 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Hans Larsen
11. BIRTHPLACE OF FATHER (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Anne Peterson
13. BIRTHPLACE OF MOTHER (State or Country): Denmark
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) I. S. Handwerk
(Address) Lewisville, Ida
15. Filed Dec 26 1916 Ray Tuck Local Registrar

BYRNS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 22 1916, to Sept. 28 1916, that I last saw her alive on Sept. 28 1916, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Myocarditis due to Malignant Goitre (Suspension)
(Duration) 2 Yrs. — mos. — ds.
Contributory (Secondary) Malignant Goitre
(Duration 4 yrs. — mos. — ds.
(Signed) J. Eisetton M. D.
Sept 28 1916 (Address) Lewisville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewisville, Ida — DATE OF BURIAL: Oct 1 1916
20. UNDERTAKER: C. E. Dinwoodey — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98

Primary Registration District No. 7176

File No. 16178

Registered No. 33

County of Jefferson

City of Rigby (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Brice Engle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH

Sept (Month) 1 (Day) 1893 (Year)

7. AGE

23 yrs. 1 mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) Laborer

9. BIRTHPLACE (State or Country) Mills Co Iowa

10. NAME OF FATHER Charles B. Engle

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Sarah E. McCoy

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles B Engle

(Address) Rigby, Box 3, Ida. No 3

15.

Filed Dec 26 1916 Ray A Fish Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

October (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1916, to Oct. 11, 1916, that I last saw him alive on Oct. 11, 1916, and that death occurred on the date stated above, at 2.50 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Hartvigsen M. D.

19 .. (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 4 mos. 11 days. In the State ..... yrs. 4 mos. 11 days.

Where was disease contracted if not at place of death? .....

Former or usual residence Fremont Co. Iowa

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rigby Ida	Oct 13 1916

20. UNDERTAKER	ADDRESS
Anson Hatch	Rigby

SYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98

County of

Primary Registration District No. 2176

File No. 16179

City of (No. , St.)

Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chloe May Pettingill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: July 30th 1916 (Month) (Day) (Year)

7. AGE: yrs. 2 mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Clark Fremont

10. NAME OF FATHER: Les Pettingill

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Lelon Nebeker

13. BIRTHPLACE OF MOTHER (State or Country): Salem Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. George Nebeker
(Address) Rigby - Rt 2

15. Filed Dec 26 1916 Ray A. Fike. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 21 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1916, to Oct 21 1916; that I last saw her alive on August 1916, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Malnutrition
(a bottle fed baby)

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. A. Anderson M. D.

Oct 23 1916 (Address) Rigby Idah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby Ida. DATE OF BURIAL: Oct 23 1916

20. UNDERTAKER: Hatch Fur. Co. ADDRESS: Rigby Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16180

Registered No. 35

1. PLACE OF DEATH.

County of Jefferson

City of Grant

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98

Primary Registration District No. 2176

(No. 1, St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Forest Fife

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept 29 1879
(Month) (Day) (Year)

7. AGE: 37 yrs. — mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home maker wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Brigham City Utah

10. NAME OF FATHER: C. P. Hathaway

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Jane Clifford

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas W Fife
(Address) Grant Rigby Idaho

15. Filed Dec 26 1916 Ray H. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 28 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 1916, to Oct 28 1916, that I last saw h[illegible] alive on Oct 27 1916, and that death occurred on the date stated above, at 6 p M.

The CAUSE OF DEATH* was as follows:
Septic Phlebitis -
Myocarditis

(Duration) 0 yrs. 1½ mos. 0 ds.

Contributory (Secondary) Chronic Interstitial Nephritis

(Duration) 5 yrs. 0 mos. 0 ds.

(Signed) Ray H. Fisher M. D.

19 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 20 yrs. mos. days. In the State 20 yrs. mos. days.

Where was disease contracted if not at place of death? 0

Former or usual residence Same

19. PLACE OF BURIAL OR REMOVAL: Grant

DATE OF BURIAL: Oct 30 1916

20. UNDERTAKER: Friends

ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO./ PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98

Primary Registration District No. 2176

File No. 16181

Registered No. 36

County of Jefferson

City of Lorenzo (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edwin Burbie Fallert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH: August 29, 1914 (Month) (Day) (Year)

7. AGE: 2 yrs. 2 mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blaine Co., Idaho.

10. NAME OF FATHER: Lorenzo Fallert

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Rose Gilson

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lorenzo Fallert
(Address) Howe Idaho

15. Filed Dec 26 1916 Ray Hibb, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 5 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 2 1916, to Nov. 5 1916, that I last saw him alive on Nov 5 1916, and that death occurred on the date stated above, at 2:40 P.M.

The CAUSE OF DEATH* was as follows:
Acute Gastroenteritis

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Christensen M. D.

Nov 6, 1916 (Address) Rigby, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 3 days. In the State 2 yrs. 3 mos. 7 days.

Where was disease contracted if not at place of death? Howe, Idaho.

Former or usual residence Howe, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Comins Ida — DATE OF BURIAL: Nov 7 1916

20. UNDERTAKER: Upson Hatch — ADDRESS: Rigby

SYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 16182
Registered No. 37

1. PLACE OF DEATH.
County of Jefferson
City of Lorenzo (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Barker
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~

6. DATE OF BIRTH: Oct (Month) 27 (Day) 1916 (Year)

7. AGE: 0 yrs. 0 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ernest Barker

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Ellis

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John T Woolsey
(Address) Pocatello Idaho

15. Filed Dec 26 1916 Ray V. Fisher. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH ~~Oct~~ Nov (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 191.., to ..... 191...,
that I last saw h..... alive on attendance 191...,
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Premature Infant

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R.H. Franks M. D.
19.... (Address) Rigby Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 14 days. In the State ..... yrs. ..... mos. 14 days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby Ida. DATE OF BURIAL: Nov 11 1916

20. UNDERTAKER: Friends ADDRESS: Rigby Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH 18

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2176
File No. 16183
Registered No. 38

1. PLACE OF DEATH.
County of Jefferson
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Robinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 1 (Day) 1881 (Year)

7. AGE: 35 yrs. 3 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James Robinson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Connell.
(Address) Rigby, Idaho.

15. Filed Dec 26 1916 Ray V. Fisher. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-30 1915, to Dec 30 1915, that I last saw him alive on July 1916, and that death occurred on the date stated above, at 9½ M.

The CAUSE OF DEATH* was as follows:

Epilepsy (Grand Mal)
Cerebral Sclerosis

(Duration) 15 yrs. — mos. — ds.

Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) Ray V. Fisher M. D.
Nov 8 1916 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby Ida. | DATE OF BURIAL: Nov 10 1916

20. UNDERTAKER: Friends | ADDRESS: Rigby R.D. 2 Ida.

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 98

Primary Registration District No. 2176

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16184

Registered No. 39

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Jefferson

City of Rigby

(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwina Ellsworth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May 4 1912 (Month) (Day) (Year)

7. AGE: 4 yrs. 8 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ed Ellsworth Jr

11. BIRTHPLACE OF FATHER (State or Country): Arizona

12. MAIDEN NAME OF MOTHER: Edwina Walker

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Orla Ellsworth
(Address) Rigby Idaho

15. Filed Dec 26 1916 Roy A. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13 1916 to Nov 14 1916, that I last saw her alive on Nov 14 1916, and that death occurred on the date stated above, at 12 15 M.

The CAUSE OF DEATH* was as follows:

Shock following Accidental severe scalding. Hot water.

(Duration) ____ yrs. ____ mos. 1 hrs. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. L. Coles M. D.

19 (Address) Rigby, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 4 yrs. 8 mos. 9 days. In the State 4 yrs. 8 mos. 9 days.

Where was disease contracted if not at place of death? ____

Former or usual residence Same

19. PLACE OF BURIAL OR REMOVAL: Rigby Ida — DATE OF BURIAL: Nov 17 1916

20. UNDERTAKER: Friends and Watch Bros. — ADDRESS: Rigby Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 16185
Registered No. 40

1. PLACE OF DEATH.
County of Jefferson
City of Rigby (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leonard Byrd Searle

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH: May 11 (Month) (Day) 1864 (Year)

7. AGE: 52 yrs. 6 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farmer.

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER John C. Searle

11. BIRTHPLACE OF FATHER (State or Country) Don't know.

12. MAIDEN NAME OF MOTHER Hall.

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Millie Searle
(Address) Rigby, Ida.

15. Filed Dec 26 1916 Ray H Fish Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. 22 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18th 191.., to Nov 22 1916
that I last saw him alive on Nov 21 1916
and that death occurred on the date stated above, at 9:30 a. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. A. Anderson M. D.
Nov 23 1916 (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby, Ida. | DATE OF BURIAL: Nov 24 1916

20. UNDERTAKER: W. C. Jones | ADDRESS: Rigby, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 16186
Registered No. 41

1. PLACE OF DEATH.
County of Jefferson
City of Rigby. (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Green

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	married

6. DATE OF BIRTH July 1 (Month) (Day) 1883 (Year)

7. AGE 33 yrs. 4 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Blacksmith

9. BIRTHPLACE (State or Country) Utah.

10. NAME OF FATHER Robt. Green

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary E. Truce

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) LeRoy Green,
(Address) Ririe, Ida.

15. Filed Dec 26 1916 Ray V. Fisher, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 29 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1916, to Nov 29 1916 that I last saw him alive on Nov 29 1916 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray V. Fisher M. D.
Nov 29 1916 (Address) Rigby, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Salt Lake City, Utah | DATE OF BURIAL Dec 2 1916

20. UNDERTAKER W. C. Jones. | ADDRESS Rigby, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 16187
Registered No. 42

1. PLACE OF DEATH.
County of Jefferson
City of Rigby. (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Murphy.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	married.

6. DATE OF BIRTH Feb. 26 1849
(Month) (Day) (Year)

7. AGE 67 yrs. 9 mos. 17 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife.
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England.

10. NAME OF FATHER Homer.

11. BIRTHPLACE OF FATHER (State or Country) England.

12. MAIDEN NAME OF MOTHER Duckmanon

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Murphy.
(Address) Rigby. R.D. 2.

15.
Filed Dec 26 1916 Ray W Fiske.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec. 12 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1916, to Dec 12 1916
that I last saw h[illegible] alive on Dec 11 1916
and that death occurred on the date stated above, at 11a M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. A. Anderson M. D.
Dec 13 1916 (Address) Rigby, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rigby, Ida.	Dec 14 1916

20. UNDERTAKER	ADDRESS
Friends.	Rigby, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 118
Primary Registration District No.
File No. 16188
Registered No.

1. PLACE OF DEATH.
County of Cassia
City of Albion
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John D. Livingston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March 13 1875 (Month) (Day) (Year)

7. AGE: 41 yrs. 8 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City. Utah.

10. NAME OF FATHER: William Livingston

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Lilias Dick.

13. BIRTHPLACE OF MOTHER (State or Country): Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Stella Livingston
(Address) Elba Idaho.

15.
Filed Dec 23 1916 R N Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1916, to 191
that I last saw him alive on Dec 6 1916,
and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis
I think he had been ailing
(Duration) 2 yrs. 3 mos. ds.
Contributory (Secondary) Has attended by Dr Bates
(Duration) yrs. 2 mos. ds.
(Signed) H A Bates M. D.
19 (Address) Albion

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elba cemetery — DATE OF BURIAL: Dec 9 1916

20. UNDERTAKER: Walter Powell — ADDRESS: Albion

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16189

Registered No. 76

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 10

Primary Registration District No. 1011

(No. Wallace Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robt Edward Bell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. January (Month) 19 (Day) 1916 (Year)

7. AGE: Yrs. 7 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wallace Ida

10. NAME OF FATHER: O. J. Bell

11. BIRTHPLACE OF FATHER (State or Country): Mississippi

12. MAIDEN NAME OF MOTHER: Dorothy Smith

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. J. Bell

(Address) Wallace Ida

15. Filed Sept 17 1916

F Leo Dunn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1916, to Sept 17 1916, that I last saw him alive on Sept 17 1916, and that death occured on the date stated above, at 9 a M.

The CAUSE OF DEATH* was as follows:

Gastro: Enteritis

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Wm T. Dunn M. D.

19 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Sept 18 1916

20. UNDERTAKER: Bruce G Wootten — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16191

Registered No. 78

Registration District No. 76

Primary Registration District No. 1001

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William McClana

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July 21st 1875 (Month) (Day) (Year)

7. AGE: 41 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: mining

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Newfoundland

10. NAME OF FATHER: Mike McLean

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Cody

13. BIRTHPLACE OF MOTHER (State or Country): Newfoundland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John B Finley

(Address) Wallace Ida

15. Filed Oct 6 1916 T Leo Funk Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1916, to Oct 4 1916, that I last saw h— alive on Oct 4 1916, and that death occured on the date stated above, at 8a M.

The CAUSE OF DEATH* was as follows:

Cancer of left lung

Following Influenza

(Duration) Yrs. 5 mos. — ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. G. Dillman M. D.

Oct 5 1916 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: Oct 7 1916

20. UNDERTAKER: Wards Und Co. — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & BOKS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16192

Registered No. 79

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 70

Primary Registration District No. 1011

County of

City of

(No. Residence St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Brent O. Skonnord

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. June (Month) 14 (Day) 1860 (Year)

7. AGE: 56 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mining

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Oslone Skonnord

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Foff

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin Skonnord

(Address) Valley City Dakota

15. Filed Oct 10 1916 T. Lee Jump Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1915, to Oct 8 1916, that I last saw h[illegible] alive on Oct 8 1916, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Hypernephroma
Left Kidney

(Duration) Yrs. 1 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. R. Mowery M. D.

Oct 11 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Oct 12 1916

20. UNDERTAKER: Wards Sundelof Co — ADDRESS: Wallace

BYRNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16193

Registered No. 80

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone Primary Registration District No. 1011

City of Wallace (No. Residence St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William McC. Kibben

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 55 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John McC. Kibben

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Ellen

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John McC. Kibben

(Address) Wallace, Ida

15. Filed Oct 18 1916 H. L. Dunn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1916, to Oct 14 1916, that I last saw h alive on Oct 14 1916, and that death occured on the date stated above, at 8:20 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. Murphy M. D.

Oct 18 1916 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Oct 18 1916

20. UNDERTAKER: Ward Hurd Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10
Primary Registration District No. 1014
(No. Wallace Hospital St.)

File No. 16194
Registered No. 81
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francis Worthington Dresskell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Nov (Month) (Day) 1915 (Year)

7. AGE
0 yrs. 11 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Cataldo

10. NAME OF FATHER K. W. Dresskell

11. BIRTHPLACE OF FATHER (State or Country) Minn

12. MAIDEN NAME OF MOTHER Geneva Dunkle

13. BIRTHPLACE OF MOTHER (State or Country) Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. L. Dunkle
(Address) .....

15. Filed Oct 23 1916 H. Leo Jungle Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
10 (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/3/16 191 , to 10/24/16 191 that I last saw h me alive on 10/22/16 191 , and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) yrs. 1 mos. ds.
Contributory (Secondary)
(Duration) yrs. 4 mos. ds.
(Signed) Howard C. Stanton M. D.
19 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 0 yrs. 1 mos. 0 days. In the State 0 yrs. 11 mos. ds.
Where was disease contracted if not at place of death? Cataldo Idaho
Former or usual residence Cataldo Idaho

19. PLACE OF BURIAL OR REMOVAL: Cataldo, Idy. | DATE OF BURIAL: Oct 23 1916

20. UNDERTAKER: B. Worstell | ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16195

Registered No. 82

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 104

(No.) Providence Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Sutherland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. .....(Month) .....(Day) 1 (Year)

7. AGE: 35 Yrs. — Mos. — ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): West Kansas

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): Oct 31 " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Providence Hospital

(Address) Wallace Ida

15. Filed Oct 30 1916 — T F Leo Jun — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1916, to Oct 23 1916, that I last saw h alive on Oct 23 1916, and that death occured on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:

Gangrene of left lung

(Duration) ..... Yrs, ... mos. 10 ds.

Contributory (Secondary) Lobar Pneumonia

(Duration) — yrs. ..... mos. 19 ds.

(Signed) D O Mowry M. D.

(Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Oct 31 1916

20. UNDERTAKER: C C Worstell — ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone — Registration District No. 70

City of Wallace — Primary Registration District No. 1011

(No. Residence Bank St.)

File No. 16196

Registered No. 85

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Cavanaugh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

6. DATE OF BIRTH.

(Month) (Day) 1 (Year)

7. AGE

74 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. B. Denny

(Address) Wallace Ida

15. Filed Nov 10 1916 — F. Leo Zinn, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 9, (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw her alive on Nov. 9 1916,

and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Old age

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Chas. K. Howry M. D.

11/10 1916 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Spokane Nash — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Ward Undertaking Co — ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16197

Registered No. 87

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011

(No. 217 Sixth St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Co Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	single

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1 (Year)

7. AGE

.....Yrs.....Mos.....ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Nat Knoxon

10. NAME OF FATHER

" "

11. BIRTHPLACE OF FATHER

(State or Country) " "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Thomas

(Address) Wallace Ida

15.

Filed Nov 3 1916 F Lee Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....191....., to .....191....., that I last saw h.....alive on .....191....., and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Ruptured aortic aneurism

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration) .....yrs.....mos.....ds.

(Signed) Chas. R. Mowry M. D.

Nov 4 1916 (Address) Wallace Ida County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Spokane Wash — DATE OF BURIAL Nov 4 1916

20. UNDERTAKER E E Worstell — ADDRESS Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SONS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 16198
Registered No. 85

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frederick Edgar Kelsey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH.
(Month) (Day) 1 (Year)

7. AGE
39 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Station agent.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Railroad

9. BIRTHPLACE
(State or Country) Michigan

10. NAME OF FATHER Chas. H. Kelsey

11. BIRTHPLACE OF FATHER
(State or Country) Ill.

12. MAIDEN NAME OF MOTHER Mary E. O'Reilley

13. BIRTHPLACE OF MOTHER
(State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hattie S. Kelsey
(Address) 718, 34th St Everett Wash

15. Filed Nov 17 1916
F Leo Jun
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11 1916, to Nov 12 1916, that I last saw h— alive on Nov 12 1916, and that death occured on the date stated above, at 3 30 M.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Diabetes
(Duration 4 yrs. mos. ds.

(Signed) Dr. H. Mowery M. D.
Nov 13 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Burke Ida

19. PLACE OF BURIAL OR REMOVAL Everett Wash. | DATE OF BURIAL Nov 13 1916

20. UNDERTAKER Ward Und Co | ADDRESS Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70

Primary Registration District No. 1911

File No. 16199

Registered No. 86

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. 208 First St. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John James Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. ~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED~~ (Write the word.): Married

6. DATE OF BIRTH. March 26 1826
(Month) (Day) (Year)

7. AGE: 90 Yrs. 7 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Menawether Brown

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Francis Brown

(Address) Wallace

15. Filed Nov 17 1916 F. Leo Jungle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13, 1916, to Nov 15 1916, that I last saw him alive on Nov 15 1916, and that death occured on the date stated above, at 4:00 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) acute Coryza

(Duration) yrs. mos. ds.

(Signed) Dr. G. Mowry M. D.

11/16 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: Nov 17 1916.

20. UNDERTAKER: By Morstell ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 4-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 1011
File No. 16200
Registered No. 87

1. PLACE OF DEATH.
County of Shoshone
City of Wallace (No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward John Flanigan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 54 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rhode Island

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lou Wheatley
(Address) Mullan Idaho

15. Filed NOV 20 1916 191 F. Leo Swindler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1916, to Nov 16 1916, that I last saw h— alive on Nov 15 1916, and that death occured on the date stated above, at 10 a M.

The CAUSE OF DEATH* was as follows:
Thoracic Aneurism
(Duration) 2 Yrs. — mos. — ds.
Contributory (Secondary) Diabetes
(Duration 6 yrs. — mos. — ds.
(Signed) Chas. A. Dietz M. D.
Nov 19 16 (Address) Chas. A. Dietz

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL: Mullan Idaho — DATE OF BURIAL: Nov 20 1916

20. UNDERTAKER: Wards Undertaking Co. — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & STRS. 24658

Primary Registration District No. 1611 C. File No. 16201

(No. Empire, Coeur d'Alene Mun. North Fork) Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Robertson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male | 4. COLOR OR RACE: White | 5. Single, Married, Widowed or Divorced. (Write the Word): Married

6. DATE OF BIRTH. .....191... (Month) (Day) (Year)

7. AGE 46 Yrs ... Mos ... ds. | IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mining engineer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nova Scotia

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): a "

12. MAIDEN NAME OF MOTHER: a "

13. BIRTHPLACE OF MOTHER (State or Country): a "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): A. J. Devlin
(Address): Spokane Wash

15. Filed Oct 3 1916 F. Leo Dunlay Local Registrar.

Place Where Remains are to be Sent: Wallace Ida | Date of Shipment: Oct 3 1916

SHIPPING UNDERTAKER: The Morelli Company
ADDRESS: Wallace ..... Firm Name: Morelli Co.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 2 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1916, to Oct 2 1916, that I last saw h.. alive on Oct 2 1916, and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(Duration) ... Years ... mos 2 ds.

Contributory (Secondary) ... (Duration) ... Years ... mos ... ds.

(Signed) J. R. Mason M. D.
Oct 2 1916 (Address) Kellogg, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)
At place of death ....yrs....mos....days | In the State ....yrs...mos...days

Where was disease contracted if not at place of death:

Former or usual residence: Spokane Wash

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida | Date of Burial: Oct 3 1916

20. UNDERTAKER: B. S. Morelli | Address: Wallace Ida

The information on this certificate is an exact COPY of the official certificate filed at place of death.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16202

Registered No. 18

1. PLACE OF DEATH.

County of Elmore

City of Mountain Home

(No. ..... St.)

Registration District No. 34

Primary Registration District No. 2020

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eliza Jane Pilner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. January (Month) 6 (Day) 1842 (Year)

7. AGE: 74 Yrs. 10 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ills

10. NAME OF FATHER: William McGuire

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Martha Wilcox

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Georgia Swasey

(Address) Mountain Home Idaho

15. Filed Nov. 11th 1916

B. O. Walker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1915, to Nov 10 1916, that I last saw h[illegible] alive on Nov 9 1916, and that death occured on the date stated above, at 4:30 A M.

The CAUSE OF DEATH* was as follows:

Rheumatism

(Duration) 1 Yrs. 1 mos. ds.

Contributory (Secondary) Pneumonitis

(Duration yrs. 1 mos. ds.

(Signed) W. H. Haggin M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Idaho | DATE OF BURIAL: Nov 12 - 1916

20. UNDERTAKER: J. M. Corwin | ADDRESS: Mountain Home Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24659

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7001
Primary Registration District No. 7001
File No. 16203
Registered No. 40

1. PLACE OF DEATH.
County of Ada
City of Star
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew Hutch Wylie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	widower

6. DATE OF BIRTH: August (Month) 27 (Day) 1827 (Year)

7. AGE: 89 yrs. 2 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry business, or dstablishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): — —

12. MAIDEN NAME OF MOTHER: — —

13. BIRTHPLACE OF MOTHER (State or Country): — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. K. Wylie
(Address) Star Idaho

15. Filed Dec 3 1917 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13 1916, to Nov 13 1916, that I last saw h[illegible] alive on Nov 13 1916 and that death occurred on the date stated above, at 1.30 P. M.

The CAUSE OF DEATH* was as follows:
Acute Pneumonia
Cardio Regurgitatio

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Extreme old age
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Fall M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetary | DATE OF BURIAL: Nov 14 1916

20. UNDERTAKER: Fry & Summers | ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 2007
File No. 16204
Registered No. 39

1. PLACE OF DEATH.
County of Canyon
City of Caldwell R.D. (No. ....., St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sephronia Emmerson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: 2 (Month) 4 (Day) 1853 (Year)

7. AGE: 63 yrs. 9 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): West Tennessee

10. NAME OF FATHER: J K Hutsell

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Nancy Hutsell

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W F Emmerson
(Address) Caldwell R.D.1 Idaho

15. Filed Nov 20 1916 Dow X cw
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 11 (Month) — 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1916, to Nov 19 1916, that I last saw her alive on Sept 21 1916 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C M Foley M. D.
11-20 1916 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glas Cemetary | DATE OF BURIAL: Nov 22 1916

20. UNDERTAKER: Fly Bennett | ADDRESS: Boise

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2001
File No. 16205
Registered No. 38

1. PLACE OF DEATH.

County of Ada
City of near Star (No. near Star St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby S Keen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 17 (Day) 1916 (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Meridian

10. NAME OF FATHER Willis S Keen

11. BIRTHPLACE OF FATHER (State or Country) Texas

12. MAIDEN NAME OF MOTHER Elmer Scrimsher

13. BIRTHPLACE OF MOTHER (State or Country) Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) B C Scrimsher
(Address) Meridian R F D 1

15. Filed Nov 28 1916 W H Hall Local Registrar

SYMS - YORK CO., PTRS. & BKRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1916, to Nov 28 1916, that I last saw her alive on Nov 28 1916, and that death occured on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:
Pneumonia

....(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary) ....
....(Duration ....yrs. ....mos. ....ds.
(Signed) P L Payne M. D.
19.... (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: Nov. 29 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2001
File No. 16206
Registered No. 37

1. PLACE OF DEATH.
County of Ada
City of Star
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Graduie Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
F M	W	

6. DATE OF BIRTH Oct (Month) 13 (Day) 1916 (Year)

7. AGE ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..8.. *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... None.
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Star Idaho

10. NAME OF FATHER Arthur J Davis

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mamie A. Davis

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur J Davis
(Address) .....

15. Filed Oct 14 1916 C C Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH October 14 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1916, to Oct 14 1916, that I last saw her alive on Oct 13 1916, and that death occurred on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows: Premature Infant, 6½ - 7 lbs

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C C Hall M. D.
10/14 1916 (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Star Cemetary | DATE OF BURIAL Oct 14 1916

20. UNDERTAKER Farber | ADDRESS Star Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 116208
Registered No. 552

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 407 S Main St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward W. Vaughn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Dec 29 1889 (Month) (Day) (Year)
7. AGE: 26 Yrs. 11 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): O.R.R. Freight House
9. BIRTHPLACE (State or Country): Wyo
10. NAME OF FATHER: John Vaughn Sr
11. BIRTHPLACE OF FATHER (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Margaret Ellis
13. BIRTHPLACE OF MOTHER (State or Country): N. Y.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Vaughn Jr
(Address) 417 So Main
15. Filed Dec 2 1916 O. P. Keller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 1 (Month) (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 1916, to Dec. 1 1916, that I last saw h.. alive on Nov. 29 1916, and that death occured on the date stated above, at 1.15 P. M.
The CAUSE OF DEATH* was as follows:
Tuberculosis of cervical glands.
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) [illegible] M. D.
12/2/1916 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Dec 3 1916
20. UNDERTAKER: Schumacher & Hall — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16209

Registered No. 553

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 318 N. Third St.)

Registration District No. 84

Primary Registration District No. 2161

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Celina Baron

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Dec 25 — 1862
(Month) (Day) (Year)

7. AGE: 54 Yrs. 11 Mos. 8 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Anthony Casseavoult

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Rosia Prairie

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Mathilda Gregoire
(Address) 416 Hayden, Pocatello

15. Filed Dec 5 1916 — O B Jones, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 3rd 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1st 1916 to Dec. 3rd 1916, that I last saw her alive on November 28th 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

12/4 1916 (Signed) Lloyd A. Gregory M. D.
(Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Dec 5 1916

20. UNDERTAKER: Schumacher & Harp — ADDRESS: City

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-45 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16210

Registered No. 554

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

Registration District No. 84

Primary Registration District No. 2161

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ethan Alphonso Lish

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. August 7th 1903 (Month) (Day) (Year)

7. AGE: 13 Yrs. 4 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School-boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) McCammon Idaho

10. NAME OF FATHER Edwin Alphonso Lish

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Sarah Leuther

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D R Lish
(Address) McCammon Ida

15. Filed Dec 9, 1916 J P Keech Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Dec. 8th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 1916, to Nov 8th 1916, that I last saw h alive on Nov 9 1916, and that death occured on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:
Post operation shock following appendectomy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute appendicitis

(Duration) 1 Yrs. 1 mos. 2 ds.

(Signed) C. Y. Smith M. D.

19.... (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dunham Idaho

DATE OF BURIAL: Dec 11 1916

20. UNDERTAKER: Dr. C. Y. Smith

ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 84

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 2161
(No. ....., ... St.)

File No. 1116211
Registered No. 5555

1. PLACE OF DEATH.
County of Bannock
City of Pocatello.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cornelia Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Widowed

6. DATE OF BIRTH.
Oct. (Month) 8 (Day) 1848 (Year)

7. AGE
68 Yrs. 2 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Salt Lake City

10. NAME OF FATHER Joseph Mount

11. BIRTHPLACE OF FATHER
(State or Country) N. J.

12. MAIDEN NAME OF MOTHER Elizabeth Bennack

13. BIRTHPLACE OF MOTHER
(State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15.
Filed Dec 14 1916
O B Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1916, to Dec 11 1916, that I last saw h[illegible] alive on Dec 11 1916, and that death occured on the date stated above, at 8 20 M.

The CAUSE OF DEATH* was as follows:
My Comm[illegible]

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs.....mos.....ds.

(Signed) [illegible] M. D.
Dec 13/16 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Ut. DATE OF BURIAL: Dec 13 1916

20. UNDERTAKER: Larkin & Sons Co ADDRESS: Pocatello.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 2465

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. ....., ... St.)

File No. 16212
Registered No. 556

1. PLACE OF DEATH.
County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Fusako Okamura

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: Y.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married
6. DATE OF BIRTH: April 19 1916 (Month) (Day) (Year)
7. AGE: ..... Yrs. 8 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Pocatello
10. NAME OF FATHER: Kanzi Okamura
11. BIRTHPLACE OF FATHER (State or Country): Japan
12. MAIDEN NAME OF MOTHER: Mayoshi Yokota
13. BIRTHPLACE OF MOTHER (State or Country): Japan
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) K. Okamura
(Address) Pocatello Idaho.
15. Filed Dec 15 1916 O B Green Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 12 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1916, to Dec 12 1916, that I last saw her alive on Dec 12 1916, and that death occured on the date stated above, at 11 30 M.
The CAUSE OF DEATH* was as follows:
Pneumonia
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... Yrs. ..... mos. ..... ds.
(Signed) F. F. Wallin M. D.
Dec 12 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days In the State .....yrs .....mos .....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida. DATE OF BURIAL: Dec. 14 1916
20. UNDERTAKER: Larkin & Doe ADDRESS: Co. Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 16213
Registered No. 557

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emile D. Farley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or widow)

6. DATE OF BIRTH. about 62 years. 1
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. Contractor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ogden Utah

10. NAME OF FATHER Emile D. Farley

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. J. Farley
(Address) Pocatello

15.
Filed Dec 16 1916 O. B. Lucas, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. 15 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1916, to Dec. 15 1916
that I last saw h[illegible] alive on Dec 15 1916
and that death occured on the date stated above, at 1[illegible] M.

The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) [illegible]
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
19..... (Address) Pocatello Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL [illegible] DATE OF BURIAL Dec. 17 1916

20. UNDERTAKER [illegible] Adkins & Sons Co ADDRESS Pocatello

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 18214
Registered No. 5558

1. PLACE OF DEATH. Registration District No. 84
County of Bannock Primary Registration District No. 2161
City of Pocatello (No. 125 N. 5th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Rossi

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Italian

6. DATE OF BIRTH. Sept 5th (Month) (Day) 1850 (Year)

7. AGE: 66 Yrs. 3 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Dominick Rossi

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Custodo Demenzuyo

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Teresa Rossi
(Address) Pocatello Ida.

15. Filed Dec 29 1916 O. Rieck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 28th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10th 1915, to Dec 28th 1916, that I last saw him alive on Dec 15th 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Carcinoma Stomach & Liver

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. A. Castle M. D.
Dec 28 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Dec 29 1916

20. UNDERTAKER: Schumacher & Harp — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

16216

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 11
Registered No. 543

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J. W. Tilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 13 (Day) 1892 (Year)

7. AGE: 24 Yrs. 1 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer): Locomotive

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: D. D. Tilson

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Rev. Kingdon
(Address) Pocatello Idaho

15. Filed Nov 14 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Fracture of Skull
Brain injury
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Barnett Woods M. D.
19.... (Address) Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cedar Mound Cem. — DATE OF BURIAL: Nov 17 1916

20. UNDERTAKER: Lawson & Jones Co — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 84

Primary Registration District No. 216

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 116217

Registered No. 543

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Lee Elkins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Mar. (Month) 23 (Day) 1865 (Year)

7. AGE: 51 Yrs. 3 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ~~Texas~~ Missouri

10. NAME OF FATHER: Elkins

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. T. Elkins

(Address) Parsons Kansas

15. Filed July 11, 1916 O. Bland Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16th 1916, to July 1st 1916, that I last saw h. in alive on July 1st 1916, and that death occured on the date stated above, at 12a M.

The CAUSE OF DEATH* was as follows: Abscess of Lungs

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

July 1st 1916 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parsons Kansas — DATE OF BURIAL: July 12 1916

20. UNDERTAKER: Larkin & Sons Co — ADDRESS: Pocatello

16218

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No. 2164
File No. 11
Registered No. 544

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Franck W. Thornhill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. November 11 1857 (Month) (Day) (Year)
7. AGE: 59 Yrs. — Mos. 5 ds.
IF LESS than 1 day how many .....hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Rail Road work.
(b) General nature of industry, business, or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Ohio
10. NAME OF FATHER: C. M. Thornhill
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Louisa Brown Thornhill.
(Address) Ogden Utah
15. Filed Nov 29 1916. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 15 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 1916, to Nov 15 1916, that I last saw h..... alive on Nov 15 1916 and that death occured on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
Hypertrophied Prostate.
.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary)
.....(Duration .....yrs. .....mos. .....ds.
(Signed) [illegible] M. D.
Nov 15 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mc Cammon Ida — DATE OF BURIAL: Nov 24 1916
20. UNDERTAKER: Schumacher Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

Dr. Newton.

CERTIFICATE OF DEATH

Registration District No. 84

Primary Registration District No. 2161

(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 11 16219

Registered No. 545

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Allie Sparks

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. April (Month) 3 (Day) 1869 (Year)

7. AGE: 47 Yrs. 7 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): Home

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: John Titus

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Eliza Spencer

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. E. Titus

(Address) 123 So. Arthur Poc. Ida.

15.

Filed Nov. 21 1916

O. P. Lucey
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH 2:20

16. DATE OF DEATH: Nov (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1916, to Nov 18 1916, that I last saw h.. alive on Nov 17 1916, and that death occured on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

..... (Duration) ..... Yrs. 1 mos. 15 ds.

Contributory (Secondary)

Arteriosclerosis (Duration ..... yrs. 2 mos. 0 ds.

(Signed) A. M. Newton M. D.

Nov 21/1916. (Address) A. M. Newton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho — DATE OF BURIAL: Nov 21 1916

20. UNDERTAKER: Larkin & Sons Co. — ADDRESS: Poc. Idaho.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. ....., ... St.)

File No. 18220
Registered No. 546

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Asa White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. June (Month) 10 (Day) 1893 (Year)
7. AGE: 23 Yrs. 5 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Real Estate Man
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Pocatello Idaho
10. NAME OF FATHER: Earle C. White
11. BIRTHPLACE OF FATHER (State or Country): Salt Lake City Ut.
12. MAIDEN NAME OF MOTHER: Annette K. Fickel
13. BIRTHPLACE OF MOTHER (State or Country): Ill
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. C. White
(Address) 209 S. 7th Ave Pocatello
15.
Filed ..... 191....
O. V. Beard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 21 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct. 23rd 1916, to Nov. 21 1916, that I last saw him alive on Nov. 21st 1916, and that death occured on the date stated above, at 10.00 A.M.
The CAUSE OF DEATH* was as follows:
Acute Parenchymatous Nephritis
(Duration) 1 Yrs. mos. 10 ds.
Contributory (Secondary) Lobar Pneumonia
(Duration) ..... yrs. ..... mos. 14 ds.
(Signed) Wm A. Wright M. D.
11/24 1916 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello — DATE OF BURIAL ..... 191....
20. UNDERTAKER: Larkin & Sons & — ADDRESS Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

Dr Nicholson

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84

Primary Registration District No. 2161

File No. 16221

Registered No. 547

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. 144 No 11th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annie Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov 23 (Month) 1855 (Day) 1 (Year)

7. AGE: 61 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Dan Patton

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: M Raspberry.

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hill

(Address) 1144 N. Eleventh

15. Filed Nov 26, 1916 J B Steele Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Nov~~ November 23 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1916, to Nov 23 1916, that I last saw h. alive on Nov 23 1916, and that death occured on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Cabar Pneumonia

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) A M. Newton M. D.

Nov 29/16 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Nov 26 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 16222
Registered No. 548

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 8 Guinn Apts. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Edwin Norene.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Nov (Month) 18 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: R. J. Norene.

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Mildred E Walters

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Roy J Norene
(Address) Pocatello Idaho

15. Filed Nov 26, 1916 O P Soady Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1916, to Nov 25 1916, that I last saw him alive on Nov 24 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Premature (5 months baby)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Francis H Poole M. D.
11/25 1916 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Nov 25 1916

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-16-13

Dr Foale

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84

Primary Registration District No. 2-461

File No. 16223

Registered No. 549

1. PLACE OF DEATH.

County of Bannock

City of Pocatello (No. Gen. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Frances Ballinger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct 7th 1857
(Month) (Day) (Year)

7. AGE: 29 Yrs. 1 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John Carr

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Mallie Watkins

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George W Ballinger
(Address) Arbon Idaho

15.
Filed Nov 29 1916
O B Steel
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov 24 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 25 1916, to Nov. 25 1916, that I last saw her alive on Nov 25 1916, and that death occured on the date stated above, at 4.25 A.M.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Ectopic pregnancy

(Duration) ..... yrs. 1½ mos. ..... ds.

(Signed) F. H. Poole M. D.

11/26 1916 (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem

DATE OF BURIAL: Nov 28 1916

20. UNDERTAKER: Schumacher & Hall

ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16224

Registered No. 350

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No. ..... Walter B. Pearce St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ~~Earl B. Shepard~~

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word): ~~Married~~

6. DATE OF BIRTH. June (Month) 16 (Day) 1898 (Year)

7. AGE: 23 Yrs. 10 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Clerk

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Arkansas

10. NAME OF FATHER William A Pearce

11. BIRTHPLACE OF FATHER (State or Country) Tennessee

12. MAIDEN NAME OF MOTHER Esther C Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert E. Pearce

(Address) Pocatello

15.

Filed ..... 191.... O P Steele Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-25 1916, to 11-26 1916, that I last saw h~~im~~ alive on 11-26 1916 and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Ac. Peritonitis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Ac. appendicitis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

11/27 1916 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida. DATE OF BURIAL: Dec 3 1916

20. UNDERTAKER: Larkin & Sons ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. ....., ... St.)

File No. 16225
Registered No. 551

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carrie B. Shepard
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. January (Month) 17 (Day) 1876 (Year)

7. AGE: 40 Yrs. 4 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Stenog
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER John C. Shepard

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Martha Catlin

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. L. Shepard
(Address) .....

15. Filed Nov 29, 1916 O B Jones Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10th 1916, to Nov 27th 1916, that I last saw h[er] alive on Nov 27 1916 and that death occured on the date stated above, at 10-45 A.M.

The CAUSE OF DEATH* was as follows:
Chronic fo arrowly mitaus nephritis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Smith M. D.
11/29 1916 (Address) 214 E Center St

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello — DATE OF BURIAL: Nov 29 1916

20. UNDERTAKER: Larkin-Sons Co — ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 58
Primary Registration District No. 2138
(No. ....., ... St.)

File No. 16226
Registered No. .....

1. PLACE OF DEATH.
County of Blaine
City of Fairfield
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Madison E Wells

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 11 (Month) 29 (Day) 1839 (Year)

7. AGE: 77 Yrs. — Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: David Wells

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Della Eddy

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E A Wells
(Address) Emmett Ida

15. Filed 12-29- 1916. D O Hyde Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-16- 1916, to 12-28 1916, that I last saw him alive on 12-28 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Delcht P Hyde M. D.
12-29-1916 (Address) Fairfield Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ore. | DATE OF BURIAL 191

20. UNDERTAKER | ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16227
Registered No. .....

1. PLACE OF DEATH.
County of Ida.
City of Wardner
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank D Freeman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 7 (Day) 1882 (Year)

7. AGE: 44 Yrs. 9 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Bridge builder & carpenter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER James Freeman

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Mary Ann Craft

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F D Freeman
(Address) .....

15.
Filed ..... 191.....
W A Inskeep
Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191....., to ..... 191....., that I last saw h.....alive on ..... 191....., and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Hemorrhage from lungs
Pleurisy and Tb
Tuberculosis
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W A Foskett M. D.
19..... (Address) Wardner Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ruggins — DATE OF BURIAL: Nov 2 191 6

20. UNDERTAKER: Hancock — ADDRESS: Wardner

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16228

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ida

City of Whitebird

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Melbourn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1890 (Year)

7. AGE: 26 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R Russell

(Address) whitebird Ida

15.

Filed ..... 191....

W A Forkett
Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1915, to Oct 1916, that I last saw h alive on Sep 20 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W A Forkett M. D.

19.... (Address) Whitebird Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Whitebird

DATE OF BURIAL: Oct 24 1916

20. UNDERTAKER: Mantt

ADDRESS: Grangeville

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16229

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

1. PLACE OF DEATH.

County of Idaho

City of Whitebird

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herman Bickel Bickel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 29 (Day) 1839 (Year)

7. AGE: 57 Yrs. 9 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: John Bickel

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Mary Ubbehard

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs H. Bickel

(Address) Campbell Ida

15.

Filed ..... 191 6 ..... W A Forkett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Fell Dead Heart failure

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W A Forkett M. D.

19.... (Address) Whitebird Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood — DATE OF BURIAL: Oct 22 1916

20. UNDERTAKER: Hancock — ADDRESS: Grangeville Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & SNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16230

Registered No. ____

Registration District No. ____

Primary Registration District No. ____

(No. ____, ____ St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ida.

City of Whitebird

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W Chamberlain

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. March (Month) 19 (Day) 1839 (Year)

7. AGE: 59 Yrs. 7 Mos. 12 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Vernon Indiana

10. NAME OF FATHER: James Chamberlain

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P Chamberlain

(Address) Boles Ida

15. Filed ____ 191____ W A Foskett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 191____ to ____ 191____, that I last saw h____ alive on ____ 191____, and that death occured on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Paralysis following
Locomotor Ataxia

(Duration) 27 Yrs. ____ mos. ____ ds.

Contributory (Secondary) Pa

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) W A Foskett M. D.

19____ (Address) Whitebird

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Whitebird — DATE OF BURIAL: Oct 18 1916

20. UNDERTAKER: Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 16231
Registered No. 847

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 3 So. of Boise St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Robert Ross

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 15th (Day) 1916 (Year)

7. AGE: ....Yrs....Mos. 10 ds.
IF LESS than 1 day how many....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada Co. Idaho

10. NAME OF FATHER: Earl Ross

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Isabel Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W H Thompson
(Address)

15. Filed Dec 26 1916
D F Leader
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15th 1916, to Dec 25th 1916, that I last saw him alive on Dec 23 1916, and that death occured on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:
Premature birth (Cause of death Weakness of Premature Baby)
(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) J Ira Bonk M. D.
12-26 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence Ada County

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL 12/25 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOOKS. 24653

Dr Book

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16232

Registered No. 88

1. PLACE OF DEATH.

County of Ada

City of

Registration District No. 8

Primary Registration District No. 2004

(No. 6 Emplacement of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James E. Logan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. June 13 (Month) (Day) 1914 (Year)

7. AGE: 2 Yrs. 6 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: James E. Logan

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Mabel Rasmussen

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James E Logan.

(Address)

15. Filed Dec 29 1916 E. H. Cotton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 27th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 5th 1916, to Dec 15th 1916, that I last saw him alive on Dec. 13th 1916, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) — Yrs. about mos. 30 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Taylor M. D.

Dec 28 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Dec 29 1916

20. UNDERTAKER: Foy & Summers Co. — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Parker

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16233

Registered No. 71

Registration District No. 8

Primary Registration District No. 2004

1. PLACE OF DEATH.

County of Ada

City of Eastick (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha M Gray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. July — 1848 (Month) (Day) (Year)

7. AGE: 70 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: James J. LaForce

11. BIRTHPLACE OF FATHER (State or Country): Not Ascertained

12. MAIDEN NAME OF MOTHER: Not Ascertained

13. BIRTHPLACE OF MOTHER (State or Country): Not Ascertained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Eastick Idaho

15. Filed Dec 9th 1916 E. F. Heaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 8 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1916, to Dec 8 1916, that I last saw h.er alive on Dec 8 1916, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) La Grippe

(Duration ..... yrs. ..... mos. 10 ds.

(Signed) O. H. Parker M. D.

19..... (Address) Mc Carty Bldg Boise Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Dec 10 1916

20. UNDERTAKER: Frye & Summers | ADDRESS: Boise Ada Co

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2008

File No. 16234

Registered No. 57

1. PLACE OF DEATH.

County of Ada

~~City or~~ near Eagle

(No. 10 Miles Down Valley Road near Linder Station)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George F. Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June 2nd (Month) (Day) 1916 (Year)

7. AGE: 87 Yrs. 6 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Conway New Hampshire

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER: not Obtainable (State or Country)

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER: not Obtainable (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J J Smith

(Address) Eagle, Ida

15. Filed Dec 11 1916

E J Neal
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 6th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1916, to Dec 6th 1916, that I last saw him alive on Nov 25th 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Mary Baer M. D.

12-7 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Ada Co, Idaho

19. PLACE OF BURIAL, OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 12/12 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16235

Registered No. 8

Registration District No. 6

Primary Registration District No. Ada

1. PLACE OF DEATH.

County of Ada.

City of Boise, (No. 720 Fair Grounds, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Ketchen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word:) Married

6. DATE OF BIRTH. Sep (Month) 6 (Day) 1878 (Year)

7. AGE: 38 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Contractor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Scotland.

10. NAME OF FATHER Arthur Ketchen

11. BIRTHPLACE OF FATHER (State or Country) Scotland.

12. MAIDEN NAME OF MOTHER Margery Lowe

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William Ketchen
(Address) 1709 N. Jefferson St

15. Filed Dec 12 1916 E. F. Clark Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9th 1916, to Dec 10th 1916, that I last saw him alive on Dec 10th 1916 and that death occured on the date stated above, at 1.20 P.M.

The CAUSE OF DEATH* was as follows:
Edema of Lungs - Terminal condition - following a cold

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Nephritis - Prostatic hypertrophy -

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Taylor M. D.

Dec 11 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Dec 12 1916

20. UNDERTAKER: Guy & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
(No. ..... St.)

File No. 16236
Registered No. 79

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ada
City of Barber

2. FULL NAME Eliza J. Gray

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 7 (Day) 1851 (Year)

7. AGE: 65 Yrs. 9 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ills

10. NAME OF FATHER: Isaac Jones

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Eliza Jones

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. H. Gray
(Address) Barber Idaho

15. Filed 12 Dec 14 1916 E F Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1916, to Dec 10 1916, that I last saw h[illegible] alive on Dec 1916, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis
2 (Duration) 7 Yrs. 2 mos. 6 ds.
Contributory (Secondary)
(Duration ... yrs. ... mos. ... ds.

(Signed) ..... M. D.
19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec. 14 1916
20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16237

Registered No. 80

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2004

(No. near Idaho City St.)

2. FULL NAME T. A. Edson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Jan (Month) 20 (Day) 1854 (Year)

7. AGE: 62 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wis

10. NAME OF FATHER Seth A Edson

11. BIRTHPLACE OF FATHER (State or Country) N. Y

12. MAIDEN NAME OF MOTHER Margt Eastman

13. BIRTHPLACE OF MOTHER (State or Country) N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs O M. Prestegard

(Address) Idaho City Ida

15. Filed Dec 14 191.....

E. F. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 13th (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191...,

that I last saw h..... alive on ——— 191...,

and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy supposed to be caused by Paralytic Stroke some time ago. Could not reach a Doctor in time before death

(Duration ..... ds.)

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.)

(Signed) Mrs O M Prestegard M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Anderson Minn.

19. PLACE OF BURIAL OR REMOVAL: Centre Mtn. | DATE OF BURIAL: 12/15 191 6

20. UNDERTAKER: Schneider Undertaking Co | ADDRESS: Boise

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16238

Registered No. 81

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. near Collister St.)

Registration District No. 8

Primary Registration District No. 2004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew P. Kiser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May 26 1848 (Month) (Day) (Year)

7. AGE: 66 Yrs. 6 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Worchester, Ohio

10. NAME OF FATHER Eli Kiser

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Mary Stillwagon

13. BIRTHPLACE OF MOTHER (State or Country) U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred J Kiser

(Address) Boise Idaho

15. Filed Dec 16 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 13 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1916, to Dec 13 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo Collister M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 12/15 1916

20. UNDERTAKER: Schneider & Eichmann | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2014

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16239

Registered No. 82

1. PLACE OF DEATH.

County of Ada.

City of Boise.

(No. Soldiers Home. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel E Elwell.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 15 (Day) 1841 (Year)

7. AGE: 75 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Pennsylvania.

10. NAME OF FATHER William Elwell.

11. BIRTHPLACE OF FATHER (State or Country) New Jersey.

12. MAIDEN NAME OF MOTHER Sarah Johnson

13. BIRTHPLACE OF MOTHER (State or Country) New Jersey.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Evan M Elwell

(Address) Clementsville Ida

15. Filed Dec 16 1916

E J Heaton
Local Registrar

SVMS - YORK CO., PTRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 191..., to ... 191...,

that I last saw h... alive on Dec 15 191...,

and that death occured on the date stated above, at 1.9 M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....

..... (Duration ... yrs. ... mos. ... ds.

(Signed) Jno Collett M. D.

12/15 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Dec 17 1916

20. UNDERTAKER: Guy & Summers Co. — ADDRESS: Boise Ida.

Idaho
DEPT. OF HEALTH
Vital Statistics

Canyon 8 [illegible] 16240

City of ..... (No. 2 miles W. of Star St.) Registered No. 83

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Moffit Haviard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, Fractions should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 8 (Day) 1880 (Year)

7. AGE: 36 Yrs. 3 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Mary E Haviard

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Helen Dodge

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. E. Haviard
(Address) Boise Ida.

15. Filed Dec 17 1916 E F Eaton Local Registrar

SYMS - YORK CO., PTRS. & BOXS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1916, to Dec 16 1916, that I last saw h[illegible] alive on Dec 16 1916 and that death occured on the date stated above, at 6.45 P M.

The CAUSE OF DEATH* was as follows:

(a) Tuberculosis

Injury

(Duration) 4 Yrs. — mos. — ds.

Contributory (Secondary) Asthma

(Duration) [illegible] Yrs. [illegible] mos. [illegible] ds.

(Signed) [illegible] M. D.

19..... (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Canyon Co. Idaho

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 12/18 1916

20. UNDERTAKER: Schreiber & Siebenfaden — ADDRESS: Boise Ida

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6
Primary Registration District No. 2004
(No. 2919 Jefferson St.)

File No. 16241
Registered No. 84
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Nicholas D. Ferguson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.

6. DATE OF BIRTH: Dec (Month) 23 (Day) 1866 (Year)

7. AGE: 49 yrs. — mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Scotland.

10. NAME OF FATHER: Geo. Ray.

11. BIRTHPLACE OF FATHER (State or Country): Scotland.

12. MAIDEN NAME OF MOTHER: Mary Templeton

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Archibald D Ferguson
(Address)

15. Filed 12/26 1916 L. H. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 24th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 13th 1916, to Dec. 24th 1916, that I last saw her alive on Dec. 24th 1916, and that death occurred on the date stated above, at 1.20 P. M.

The CAUSE OF DEATH* was as follows:
Inanition, nervous exhaustion, from inability to take nourishment due to irritability of Stomach and vomiting &c.
(Duration) — yrs. — mos. 7 ds.
Contributory (Secondary) inherited high nervous tension & physical weakness,
(Duration) yrs. mos. ds.
(Signed) George O. Haley M. D.
Dec. 24th 1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Dec 26 1916

20. UNDERTAKER: Fry & Summers Co. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

8

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16242

Registered No. 82

1. PLACE OF DEATH.

County of Ada.

City of 5 mi. So West of Boise. (St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 2007

2. FULL NAME Benjamin F. Lowrey.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): M.

6. DATE OF BIRTH.

Apr. — 1833
(Month) (Day) (Year)

7. AGE

83 Yrs. 8 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Missouri.

10. NAME OF FATHER: Not Obtainable.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [signature]

(Address) 1119 Bank St. Boise Ida

15.

Filed Dec 27 1916

[signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 26 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1916, to Dec 26 1916, that I last saw h. alive on Dec 26 1916, and that death occured on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Peritonei

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M.D.

19 (Address) 409 Eastman Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Dec 28 1916

20. UNDERTAKER: Foy & Summers Co. ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & ENGS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16243

Registered No. 86

1. PLACE OF DEATH.

County of Ada.

City of North [redacted] of Boise (No. Moores Creek, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ennis Furrer.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 28 (Day) 1864 (Year)

7. AGE: 52 Yrs. 9 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Lumberman.

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Charles B Furrer

11. BIRTHPLACE OF FATHER (State or Country): Switzerland.

12. MAIDEN NAME OF MOTHER: Barbra Shadd.

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Peter Weber

(Address) .....

15. Filed Dec 27 1916

E. F. Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,

that I last saw h— alive on — 191...,

and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Dam him dead - death
due apparently to apoplexy

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration ... yrs. ... mos. ... ds.

(Signed) Edward F Burke M. D.

12/27 1916 (Address) Idaho Gas Bldg

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Dec 27 1916

20. UNDERTAKER: Fry & Summers Co. — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16244

Registered No. 13

1. PLACE OF DEATH.

County of Ada.

City of 4 mi west of Boise

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Rosalie Howe.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 28 (Day) 1906 (Year)

7. AGE: 10 Yrs. 10 Mos. 5 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Oklahoma.

10. NAME OF FATHER: Delmus B Howe.

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin.

12. MAIDEN NAME OF MOTHER: Elizabeth Birchfield

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Paul Howe
(Address) Box 103, Boise, Idaho

15.
Filed .....191....
E. L. Coston
Local Registrar

SYMS - YORK CO., PTRS. & BKRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1916, to Dec 3 1916, that I last saw h[illegible] alive on Dec 3 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

[illegible]

.....(Duration) ..... Yrs. — mos. — ds.

Contributory (Secondary) [illegible]

.....(Duration ..... yrs. ..... mos. 1 ds.

(Signed) [illegible] M. D.

19.... (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Nov 4 1916

20. UNDERTAKER: Fry & Summers Co. — ADDRESS: Boise Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 16215
Registered No. 74

1. PLACE OF DEATH.
County of Ada
City of Eagle (No. Near Eagle St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Records

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 23 (Day) 1916 (Year)

7. AGE: ....Yrs. ....Mos. 13 ....ds.
IF LESS than 1 day how many ....hrs. or ....min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada Co

10. NAME OF FATHER: Alfred Records

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Edith Brown

13. BIRTHPLACE OF MOTHER (State or Country): Nebr

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H S Records
(Address) Boise

15. Filed 12/6 1916 E. F. Heaton Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1916, to Dec 5 1916, that I last saw him alive on Dec 5 1916, and that death occured on the date stated above, at 3 20 P.M.

The CAUSE OF DEATH* was as follows:
Patent foramen ovale

(Duration) ....Yrs. ....mos. 11 ....ds.

Contributory (Secondary)
(Duration ....yrs. ....mos. ....ds.

(Signed) Maurice Hallinan M. D.
12/5 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery — DATE OF BURIAL: Dec. 6 1916

20. UNDERTAKER: Schreiber & Hidenfeldt — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16246

Registered No. 72

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.

County of Ada

City of near Boise

(No. Route 7 St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

2. FULL NAME Infant Lillegard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 14 (Day) 1916 (Year)

7. AGE ..... Yrs. 1 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or 19 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Carl Lallagard

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Mary Paulson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl Lillegard

(Address) Boise R F D # 1

15. Filed Dec 4 1916

E. F. Slater Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2nd 1916, to Dec 3rd 1916, that I last saw him alive on Dec 2nd 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Strangulation

During an attack of

convulsions.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. W. Beck M. D.

12-4 1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Joplin Cemetery — DATE OF BURIAL: Dec 4 1916

20. UNDERTAKER: Gray & Summers — ADDRESS: Boise Idaho

SYMS - YORK CO., PTRS. A 8868, 24652

FORM V. S. No. 5-25 M. 1-16-18

Forney

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 16247
Registered No. 73

1. PLACE OF DEATH.
County of Ada
City of 5½ mi west of Boise (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Michael W. Weavers.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M.	White	Married (write the word.)

6. DATE OF BIRTH.
Oct (Month) 4 (Day) 1848 (Year)

7. AGE 68 Yrs. 2 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)... —

9. BIRTHPLACE
(State or Country) Pennsylvania.

10. NAME OF FATHER Jes Weavers.

11. BIRTHPLACE OF FATHER
(State or Country) Pennsylvania.

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER
(State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. A. Weaver
(Address) Boise, Idaho

15.
Filed Dec 4 1916
D. F. Leahy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1916, to Dec 3 1916, that I last saw him alive on Dec 3 1916, and that death occured on the date stated above, at 6½ M.

The CAUSE OF DEATH* was as follows:

Bright disease
Chronic T. B. Bronchitis
(Duration) 15 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Forney M. D.
12/15 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Dec 6 1916
20. UNDERTAKER	ADDRESS
Fryer Summers Co.	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16248

Registered No. 71

1. PLACE OF DEATH.

County of Ada

City of Soldiers Home.

(No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cary P. Taplin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. (Month) (Day) 1843 (Year)

7. AGE: 73 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. Veteran Civil War
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Not Obtainable

10. NAME OF FATHER Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. H. Barton
(Address) Soldiers Home,

15.
Filed Dec 4 1916. E. H. Eaton
Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Dec (Day) 3 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1916, to Dec 4 1916, that I last saw him alive on Dec 3 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Colvert M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 5 1916

20. UNDERTAKER: Terry & Sherman — ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16249
Registered No. 277

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mariana Barinaga

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May 2nd (Month) (Day) 1916 (Year)

7. AGE: ——— Yrs. 7 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho.

10. NAME OF FATHER: Joseph Barinaga

11. BIRTHPLACE OF FATHER (State or Country): Spain.

12. MAIDEN NAME OF MOTHER: Santa Bilbo

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Santa Barinaga

(Address) Mt Home R.

15. Filed 12/5 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 4th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1916, to Dec 4 1916, that I last saw her alive on Dec 3 1916 and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

12/4 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Mt Home, Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 12/5 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 16250

Registered No. 305

1. PLACE OF DEATH.

County of Ada.

City of Boise.

(No. 119 No 17 St. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stephen M. Sisk.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M.	White	Married (or widowed)

6. DATE OF BIRTH.

May 30 1833
(Month) (Day) (Year)

7. AGE

83 Yrs. 8 Mos. 30 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Kentucky

10. NAME OF FATHER Martin Sisk

11. BIRTHPLACE OF FATHER

(State or Country) North Carolina.

12. MAIDEN NAME OF MOTHER Minnie Murphy

13. BIRTHPLACE OF MOTHER

(State or Country) Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katharine Stofiel

(Address) .....

15.

Filed 12/30 1916

E. A. Cotton
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 - 29 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1916, to Dec 29 1916, that I last saw h sm alive on Dec 28 1916, and that death occured on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:

Ulcer of stomach

(Duration) 1/2 Yrs. mos. ds.

Contributory (Secondary) Hemorrhage

(Duration yrs. mos. 2 ds.

(Signed) Maurice Tallman M. D.

12/30 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE. (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Masonic Cemetery	Dec 31 1916
20. UNDERTAKER	**ADDRESS**
Fry & Summers Co.	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 16251
Registered No. 30303

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 110, East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Andrews

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. June (Month) 5 (Day) 1884 (Year)

7. AGE 32 Yrs. 6 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER H. D. Andrews

11. BIRTHPLACE OF FATHER (State or Country) Don't know

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. W. Graham
(Address) Caldwell Idaho

15. Filed 12/29 1916
E. A. Cubon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15th 1916, to Dec 28 1916, that I last saw him alive on Dec 28 1916, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Kidney and Bladder

(Duration) 8 Yrs. mos. ds.

Contributory (Secondary) .....
(Duration ..... yrs. mos. ds.

(Signed) J. S. Springer M. D.
Dec 29 1916 (Address) Boise.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Caldwell

19. PLACE OF BURIAL OR REMOVAL Caldwell | DATE OF BURIAL [illegible] 1916

20. UNDERTAKER Schrieber & Hildreth | ADDRESS Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16252

Registered No. 302

1. PLACE OF DEATH.

County of Ada.

City of Boise.

(No. 708 N. Thirty Ave. St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wade D. Weaver.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M.	White	Single (Write the word.)

6. DATE OF BIRTH.

Oct 16 1916.
(Month) (Day) (Year)

7. AGE

Yrs. 2 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None.

(b) General nature of industry, business, or establishment in which employed (or employer)... —

9. BIRTHPLACE

(State or Country) Idaho.

10. NAME OF FATHER Irvin Weaver.

11. BIRTHPLACE OF FATHER

(State or Country) Missouri.

12. MAIDEN NAME OF MOTHER Bess Sanders.

13. BIRTHPLACE OF MOTHER

(State or Country) So. Dakota.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Weaver.

(Address) .....

15. Filed 12/26 1916 E A Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 25 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1916, to Dec 25 1916, that I last saw him alive on Dec 24 1916, and that death occured on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) W S Lutz M. D.

12-27-1916 (Address) Boise.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Dec 26 1916
20. UNDERTAKER	**ADDRESS**
Terry & Summers Co.	Boise. Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24853

FORM V. S. No. 3-15 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16253

Registered No. 301

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1094

County of Ada

City of Boise

(No. St Alphonsus Hospital)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary D. Jessup.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married

6. DATE OF BIRTH. (Month) Aug (Day) 17 (Year) 1866

7. AGE: 49 Yrs. 4 Mos. 7 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri.

10. NAME OF FATHER: Geo Beasley.

11. BIRTHPLACE OF FATHER (State or Country): Illinois.

12. MAIDEN NAME OF MOTHER: Elizabeth Trabue

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) Edwin P Jessup

15. Filed 12/26 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 1916, to Dec 24 1916, that I last saw her alive on Dec 24 1916, and that death occured on the date stated above, at 2P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) W S Lister M. D.

(Address) Boise

(12-27 1916)

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell Idaho. DATE OF BURIAL: Dec 27 1916

20. UNDERTAKER: Frye Summers Co ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

STHS - YORK CO., PTRS. & STNR. 24628

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 16254

Registered No. 300

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel Basick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1870 (Year)

7. AGE about 40 Yrs. ... Mos. ... ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Rosenbloom
(Address) Boise

15. Filed 12/23 1916

E. A. Cutter
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 22nd 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1915 to Dec 22nd 1916, that I last saw h... alive on Dec 22 1916, and that death occured on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis

(Duration) 2 Yrs. 2 mos. — ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. Sandford M. D.

19... (Address) Eamper Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence: Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: Dec. 24 1916

20. UNDERTAKER: Schreiber & Anderson — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16255

Registered No. 299

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Herman Foster

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb (Month) 28th (Day) 1900 (Year)

7. AGE 16 Yrs. 11 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Denver Colo.

10. NAME OF FATHER W. A. Foster

11. BIRTHPLACE OF FATHER Iowa (State or Country)

12. MAIDEN NAME OF MOTHER Martha J. Martin

13. BIRTHPLACE OF MOTHER Mo. (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. A. Foster
(Address) Boise Ida.

15. Filed 12/22 1916 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1916, to Dec 21 1916, that I last saw h[illegible] alive on Dec 20 1916, and that death occured on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis

(Duration) Yrs. mos. 8 ds.

Contributory (Secondary) .....(Duration ... Yrs. ... mos. ... ds.

(Signed) W. S. Liter M. D.
12-21 1916 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 12/22 1916

20. UNDERTAKER: Schroeder Undertaking Co. — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 6-16 R. 1-16-15

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16256

Registered No. 298

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 1004

County of Ada

City of Boise (No. 410 Hale St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Effie M. Calloway

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb 1 1896 (Month) (Day) (Year)

7. AGE: 21 Yrs. 10 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None -

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mt. Home Ida.

10. NAME OF FATHER: W. S. Calloway

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Ida Isgroth

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Stanton Park

(Address) Mt. Home Ida.

15. Filed 12/21 1916

E. J. Cahn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 20th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17th 1916, to Dec 20th 1916, that I last saw h.. alive on Dec 20th 1916, and that death occured on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) John Burke M. D.

12-21-1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Mountain Home

19. PLACE OF BURIAL OR REMOVAL: Mountain Home | DATE OF B... Dec 22 1916

20. UNDERTAKER: Schreiber & Sederquist | ADDRESS: Boise

STYER - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics.

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 110 E. Bannock St.)

Registration District No. 2

Primary Registration District No. 1004

File No. 16257

Registered No. 297

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John M. Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May 22 (Month) (Day) 1867 (Year)

7. AGE: 49 Yrs. 6 Mos. 25 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Logger

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not obtainable

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clyde B. Summers

(Address) Boise Idaho

15.

Filed 12/20 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1916, to Dec 16 1916, that I last saw h.[illegible] alive on Dec 16 1916, and that death occured on the date stated above, at 8:15 P. M.

The CAUSE OF DEATH* was as follows:

Fracture of skull
basal, Vault & base
and, Crushing brain:

(Duration) Yrs. mos. ds.

Contributory (Secondary) Tree fell on head

(Duration) yrs. mos. ds.

(Signed) L. P. McCallie M. D.

12/17 19 16 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Dec 21 1916

20. UNDERTAKER: Fry & Summers

ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16258

Registered No. 296

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. Hurtt Apartments St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Harrison Puckett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. August (Month) 8 (Day) 1869 (Year)

7. AGE: 47 Yrs. 4 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Attorney at Law

(b) General nature of industry, business, or establishment in which employed (or employer): Legal Profession

9. BIRTHPLACE (State or Country): Near Paducah in Kentucky

10. NAME OF FATHER: William J. Puckett

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Josephine Reeves

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas Hawley

(Address) American Reg Bldg Boise Ida

15. Filed 12/19 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1912, to Dec. 18 1916, that I last saw him alive on Dec. 18 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 5 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) J Carl Hill M. D.

12/18/1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 12/20 1916

20. UNDERTAKER: Schreiber & Lieuallen — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK GD., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

McCalls

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 16259
Registered No. 285

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1118 Fee St. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Belle Godwin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 5 (Day) 1853 (Year)

7. AGE: 63 Yrs. 4 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Chas Rice

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Abigail Trumbull

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Bernice Godwin
(Address) 1118 Fee St. Boise

15. Filed 12/19 1916

W. C. [illegible]
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1916, to Dec 16 1916, that I last saw her alive on Dec 16 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Bronchitis Chronic Nephritis
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. G. McCalla M. D.
12/17 1916. (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 19 1916

20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16260
Registered No. 294

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 State St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004

2. FULL NAME James O'Neill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 6 (Day) 1862 (Year)

7. AGE: 54 Yrs. 6 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mining
(b) General nature of industry, business, or establishment in which employed (or employer): Roundout N. Y.

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Mr. O'Neill

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Honora Mullroy

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. A. O'Neill
(Address) Atlanta Ida.

15. Filed 12/18 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 14 1916, to Dec. 17 1916, that I last saw him alive on Dec 16 1916, and that death occured on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas V. Kenney M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence: Mountain Home Ida

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 12/18 1916

20. UNDERTAKER: Thurber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOS. 24658

Dr Greenwey.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16261

Registered No. 792

1. PLACE OF DEATH.

County of Ada

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

(No. 1407 Lewis St. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mandy V. March

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. — (Month) — (Day) 1856 (Year)

7. AGE: 60 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Miles

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Everett March

(Address) .....

15. Filed 12/16 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — (Month) 12 (Day) 14 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,

that I last saw h— alive on — 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Probably mitral stenosis with auricular fibrillation

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Maurice Dalbym M. D.

12/16 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill. DATE OF BURIAL: Dec 17 1916

20. UNDERTAKER: Frye & Summers Co. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16262

Registered No. 291

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 1319 N. 6th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George A. Shafter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Married

6. DATE OF BIRTH. March (Month) 3 (Day) 1835 (Year)

7. AGE 81 Yrs. 9 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Miner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER George Shafter.

11. BIRTHPLACE OF FATHER (State or Country) Not obtainable

12. MAIDEN NAME OF MOTHER Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country) Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. M. Calvin

(Address) 1319 N. 6th St.

15. Filed 12/14 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 13th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5th 1916, to Dec 13th 1916, that I last saw h~~im alive on~~ found dead 12 M., and that death occured on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Senility

worn heart complicated

Tissues.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) 0

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Baeck M. D.

12-16 1916 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	191
20. UNDERTAKER Frye & Summers	ADDRESS [redacted]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16263

Registered No. 240

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jose Lizarralde Rayon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 17 (Day) 1866 (Year)

7. AGE: 50 Yrs. 3 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Pedro Maria Lizarralde

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Martina Josefa Otamendi

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Aguirre
(Address) Boise Idaho

15. Filed 12/16 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1916, to Dec 14 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 12/16 1916

20. UNDERTAKER: Schaefer & Eichenlaub — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 16264

Registered No. 2897

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 401 Main St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orin Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. February (Month) 13 (Day) 1893 (Year)

7. AGE 23 Yrs. 10 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Janitor

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Isaac B. Evans

11. BIRTHPLACE OF FATHER (State or Country) Brigham Co. Utah

12. MAIDEN NAME OF MOTHER Elizabeth Price

13. BIRTHPLACE OF MOTHER (State or Country) Samaria Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) P.O. Preston Idaho

15. Filed 12/14 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11th 1916, to Dec 13th 1916, that I last saw him alive on Dec 13th 1916, and that death occured on the date stated above, at Noon M.

The CAUSE OF DEATH* was as follows:

Pleuro - Pneumonia

(Duration) ..... Yrs. ..... mos. 1 2 ds.

Contributory (Secondary) La Grippe

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) J. E. Kroom M. D.

12-13 1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston Idaho	12/16 1916

20. UNDERTAKER	ADDRESS
Schmid & Sidwell	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16265

Registered No. 288

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jacob Hamm.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. April 16th 1850 (Month) (Day) (Year)

7. AGE: 66 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oneida Co. N.Y.

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. W. Sloan

(Address) Boise

15.

Filed 12/15 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 13th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8th 1916, to Nov 15th 1916, that I last saw him alive on Nov 15 1916, and that death occured on the date stated above, at ——— M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy ?

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. D. R. Numbers M. D.

19.... (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 12/16 1916

20. UNDERTAKER: Schubert & Richardson — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Numbers

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16266

Registered No. 287

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Burns

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. May (Month) 1 (Day) 1842 (Year)

7. AGE: 74 Yrs. 1 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: — Berry

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lola Kanaa

(Address) 704 S 17 St

15. Filed 12/14 1916

Local Registrar

8YMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1916, to Dec 11 1916, that I last saw h. alive on Dec 11 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Cancer Intestines

(Duration) Yrs. 8 mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 13 1916. (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hillcrest DATE OF BURIAL: Dec 14 1916

20. UNDERTAKER: Fry & Kennedy ADDRESS: Boise Ida

FORM V. S. No. 5-25 Rev. 1915

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 16267

Registered No. 286

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 110, East Bannock, St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dexter Geo Cahoon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 7th (Day) 1851 (Year)

7. AGE: 65 Yrs. — Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Business Organizer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canton N.Y.

10. NAME OF FATHER: Geo. P. Cahoon

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Salvia Brown

13. BIRTHPLACE OF MOTHER (State or Country): Vermont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Earl W Cahoon
(Address) 901 N. 15th Boise Ida.

15. Filed 12/13 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1916 to Dec 12 1916, that I last saw h... alive on ... 191..., and that death occured on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration ... yrs. ... mos. ... ds.

(Signed) Leo Collister M. D.

19.... (Address) ...

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 12/14 1916

20. UNDERTAKER: Schreiber & Hedenstedt | ADDRESS: Boise

SYMS - YORK CO., PTRS. & STRS. 24658

Dr. Collister

FORM V. S. No. 5-38 M 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 16268

Registered No. 285

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 1108 E. Bannock St.,

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John James Bennett

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 15 (Day) 1863 (Year)

7. AGE: 53 Yrs. 4 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mine Superintendent
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER John Bennett

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mrs Kate Bullaways

13. BIRTHPLACE OF MOTHER (State or Country) England Not Certain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John R. Hall
(Address) 1109 East Jefferson St

15. Filed 12/13 191 6

E. A. Cahn
Local Registrar

SVMS - YORK CO., PTRS. & SOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1916, to Dec 10th 1916, that I last saw him alive on Dec 10th 1916, and that death occured on the date stated above, at 6:30 a M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 9 ds.

Contributory (Secondary) Cardiac Asthma

(Duration 20 yrs. mos. ds.

(Signed) Jno R Summers M. D.

12/11 1916 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 14 1916

20. UNDERTAKER: Frye & Summers — ADDRESS: Boise Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16269
Registered No. 284

1. PLACE OF DEATH.
County of Ada
City of Boise
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 2
Primary Registration District No. 1004
(No. 1 D Lukes Road St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ulric K. Furrle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Single

6. DATE OF BIRTH. Aug. (Month) 5 (Day) 1881 (Year)

7. AGE 35 Yrs. 4 Mos. 7 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER C. J Furrle

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Jennie Kreppe

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary A. Burnett
(Address) Vasco, Oregon

15. Filed 12/15 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 1916, to Dec. 12 1916, that I last saw him alive on Dec. 12 1916, and that death occured on the date stated above, at 3.30 P.M.
The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) Yrs. 2 mos. 5 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. Carl Keil M. D.
12/12 1916. (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
San Francisco Cal.	Dec. 16 1916
20. UNDERTAKER	ADDRESS
Gray Summers	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
(No. ....., ... St.)

File No. 16270
Registered No. 283

1. PLACE OF DEATH.
County of Ada.
City of Ls Boise
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy A. Bibbins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): W

6. DATE OF BIRTH. July (Month) 31 (Day) 1837 (Year)

7. AGE: 79 Yrs. 4 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Mass.

10. NAME OF FATHER Not Obtainable

11. BIRTHPLACE OF FATHER
(State or Country) Not Obtainable

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER
(State or Country) Not Obtainable.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Walker & Bruce
(Address)

15.
Filed 12/11 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Died suddenly. Probably
Apoplexy - Was not fully
after death.

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. L. Williamson M. D.
19... (Address) 824 Franklin St

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Dec 13 1916

20. UNDERTAKER: Guy & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16271
Registered No. 281

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No. 1004

County of Ada

City of Boise (No. 410 Hale St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas David Collins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. May (Month) 5th (Day) 1866 (Year)

7. AGE: 50 Yrs. 7 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Mining

(b) General nature of industry, business, or establishment in which employed (or employer)... Standard Mining Co.

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Thomas Collins

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Collins

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. J. Lafoss

(Address) Boise Idaho

15. Filed 12/10 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 7th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 17 1916, to Dec 7 1916, that I last saw h[illegible] alive on Dec 6 1916, and that death occured on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 20 ds.

Contributory (Secondary): Myocarditis

(Duration ... yrs. ... mos. ... ds.

(Signed) J. J. Goodnight M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Dec 9 1916

20. UNDERTAKER: Schreiber & Redemann | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16272

Registered No. 280

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 1319 N 15 St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James P. Simmons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1844 (Year)

7. AGE: 75 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Not Obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not Obtainable

12. MAIDEN NAME OF MOTHER: Not Obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. L. Holsted

(Address) 1319 N. 15th

15. Filed 12/10 191 6

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5th 1916, to Dec 8th 1916, that I last saw him alive on Dec 7th 1916, and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 0 Yrs. mos. ds.

Contributory (Secondary) La Grippe

(Duration) 1 yrs. mos. ds.

(Signed) J. Mullbach M. D.

12-8 1916 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 10 1916

20. UNDERTAKER: Trip & Summers — ADDRESS: Boise Ida

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. St. Alphonsus Hosp St.)

File No. 16273

Registered No. 279

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Sherman Howe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 8 (Day) 1833 (Year)

7. AGE: 83 Yrs. 4 Mos. 24 ds.

IF LESS than 1 day how many .....hrs. or .....min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Civil Engineer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Jotham Howe

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Annah Howe

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Harriet Sophia Howe
(Address) 408 Resaquin St Boise Ida

15. Filed Dec 4th 1916 — E. H. Eaton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 2nd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st 1916, to Dec 2nd 1916, that I last saw h[illegible] alive on Dec 2 1916, and that death occured on the date stated above, at 1.10 P. M.

The CAUSE OF DEATH* was as follows:
Arteria Sclerosis and
General Senile Decay.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. P. McCalla M. D.

19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 5 1916

20. UNDERTAKER: Terry & Summers — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, FRACTIONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 16274 278
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 1502 N. 27th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Irene May Stone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 24th (Day) 1910 (Year)

7. AGE: ——Yrs. 6 Mos. 10 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho,

10. NAME OF FATHER: L. S. Stone

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Emma Baker

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant):
(Address): L. S. Stone, Boise

15. Filed 12/5 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 4th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1916, to Dec 3 1916, that I last saw h[er] alive on Dec 3 1916, and that death occured on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:
Marasmus

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) H. M. Robertson M. D.
19 (Address) 317 Empire B

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 12/5 1916

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Ida

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16276

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lehm

City of Driggs

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 77

Primary Registration District No. 216

(No. ....., ... St.)

2. FULL NAME Myrth Cole

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 31 (Day) 1914 (Year)

7. AGE: 1 Yrs. 9 Mos. 26 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: E. H. Cole

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Holden

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TREE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. H. Cole
(Address) Driggs Idaho

15. Filed 10-27 1916 M. Chenault Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
10 (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-16th 1916, to Oct 27th 1916, that I last saw h[er] alive on Oct-26th 1916, and that death occured on the date stated above, at 4:45 P. M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ben F Roseman M. D.

10/27/1916 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt Driggs Idah — DATE OF BURIAL: 10-28 1916

20. UNDERTAKER: Moe — ADDRESS: [illegible]

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16277
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
Registration District No. 77
Primary Registration District No. 2176
County of Teton
City of Driggs
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thorn Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
6. DATE OF BIRTH: x (Month) x (Day) 1 x (Year)
7. AGE: ... yrs. ... mos. ... ds. IF LESS than 1 day how many ... hrs. or ... mins.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Driggs
10. NAME OF FATHER: H B. Johnson
11. BIRTHPLACE OF FATHER (State or Country): Preston
12. MAIDEN NAME OF MOTHER: Mae Christiansen
13. BIRTHPLACE OF MOTHER (State or Country): Blackfoot
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Johnson
(Address) Driggs Idaho
15. Filed 11 - 30 1916 C Cherrington Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 11 (Month) 24 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 11-24 1916, to 11 - 24 1916 that I last saw her alive on 11 - 24 1916 and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
Atelectasis.
(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary) 17 hours
(Duration) ... yrs. ... mos. ... ds.
(Signed) Ben F. Rosenau M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Driggs — DATE OF BURIAL: 11 - 25 1916
20. UNDERTAKER: C Cherrington — ADDRESS: Driggs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16278

Registered No. .....

Registration District No. 125

Primary Registration District No. 2203

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of Kilgore

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Birda Kemp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH. Jan (Month) 9 (Day) 1884 (Year)

7. AGE 27 Yrs. 10 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Georgia

10. NAME OF FATHER L C Burns

11. BIRTHPLACE OF FATHER (State or Country) Georgia

12. MAIDEN NAME OF MOTHER Fannie E Burns

13. BIRTHPLACE OF MOTHER (State or Country) Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna Kemp

(Address) Rexburg Idaho

15. Filed Dec 5 1916 C E Jones M D Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1916, to Dec 3 1916, that I last saw her alive on Dec 3 1916, and that death occured on the date stated above, at 4-9 M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C E Jones M. D.

12-5 1916 (Address) St Anthonis Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rexburg Idaho | **DATE OF BURIAL** 12-6 1916

20. UNDERTAKER None | **ADDRESS**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16279

Registered No. .....

Registration District No. 125

Primary Registration District No. 2202

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of Dubois

2. FULL NAME Baby – Bezold

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 12 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 1 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Dubois Idaho

10. NAME OF FATHER Otto F Bezold

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Ethel R Gibson

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Otto F Bezold

(Address) Winspur Idaho

15. Filed Dec 13 1916

C E Jones M D

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10:10 PM Dec 12 1916, to 11:10 PM Dec 12 1916, that I last saw him alive on Dec 12 1916, and that death occured on the date stated above, at 11:10 PM.

The CAUSE OF DEATH* was as follows:

Premature Birth

1 hour

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C E Jones M. D.

12-13 1916. (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dubois Idaho — DATE OF BURIAL: Dec 13 1916

20. UNDERTAKER: None — ADDRESS: —

BYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 125
Primary Registration District No. 2203
(No. ..... St.)

File No. 16280
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of Dubois
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie L Ellerman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov (Month) 9 (Day) 1916 (Year)

7. AGE ..... Yrs. 1 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Dubois Idaho

10. NAME OF FATHER Everard C Ellerman

11. BIRTHPLACE OF FATHER (State or Country) Australia

12. MAIDEN NAME OF MOTHER Enid M Benson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Everard C Ellerman
(Address) Dubois Idaho

15. Filed Dec 14 1916 C E Jones M D Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3 P M. Dec 13 1916, to 11 P M Dec 13 1916, that I last saw h er alive on Dec 13 1916, and that death occured on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Acute Gastritis
8 hours.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C E Jones M. D.
12-14 1916 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dubois Idaho — DATE OF BURIAL: Dec 15 1916

20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & PRNS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2136
File No. 16281
Registered No. ____

1. PLACE OF DEATH.

County of Bear Lake
City of Montpelier
(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Earl Rowley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. May (Month) 1st (Day) 1916 (Year)

7. AGE: Yrs. 6 Mos. 27 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Earl Rowley

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Mabel Long

13. BIRTHPLACE OF MOTHER (State or Country): Wyoming.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. T. Long
(Address) Montpelier, Idaho

15. Filed 12/30/ 1916 H. H. Kinney Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1916, to Dec 28 1916, that I last saw him alive on Dec 28 1916, and that death occured on the date stated above, at 9.25 A.M.

The CAUSE OF DEATH* was as follows:
Convulsions of unknown Etiology.
(Duration) Yrs. ____ mos. 2 ds.
Contributory (Secondary) Broncho pneumonia
(Duration ____ yrs. ____ mos. ____ ds.

(Signed) J. W. Lyon M. D.
12/30/16 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Montpelier	Dec. 30 1916
20. UNDERTAKER F. M. Williams	ADDRESS Montpelier,

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 52

Primary Registration District No. 2136

File No. 16282

County of Bear Lake

City of Montpelier (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lyman Murphy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): baby

6. DATE OF BIRTH: Dec 19 (Month) 3 hours (Day) 1916 (Year)

7. AGE: 3 hrs yrs. ..... mos. ..... ds.

IF LESS than 1 day how many 3 hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: infant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bear Lake

10. NAME OF FATHER: Geo D Murphy

11. BIRTHPLACE OF FATHER (State or Country): Utah Lucilla county

12. MAIDEN NAME OF MOTHER: Edith Langford

13. BIRTHPLACE OF MOTHER (State or Country): Bear Lake

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George D. Murphy
(Address) Montpelier Idaho

15. Filed, Dec. 21st 1916 H H Rees Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec 19-1916 3 hours 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1916, to ..... 1916, that I last saw him alive on Dec 19 1916, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows: Unknown (premature)

(Duration) 3 hrs yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D J H Lapham M. D.

12/19 1916 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida — DATE OF BURIAL: 12/21 1916

20. UNDERTAKER: J. Seebach — ADDRESS: Montpelier

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8 — Bear Lake
Primary Registration District No. 2136
(No. ..... St.)
File No. 16283
Registered No. .....

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Murphy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec 19 (Month) (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Montpelier

10. NAME OF FATHER George D. Murphy

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Edith Langford

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George D. Murphy
(Address) Montpelier Ida.

15. Filed Dec 21 1916. H. H. Sharp Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1916 to Dec 1916, that I last saw h..... alive on Dec 19 1916, and that death occured on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows: Unknown
(a) Premature - Twin Gestation
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Dyer M. D.
12/19 1916 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida — DATE OF BURIAL: 12/21/1916

20. UNDERTAKER: F. Sarbach — ADDRESS: Montpelier

FORM V. S. No. 5-36 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 213
(No. ..... St.)

File No. 16284
Registered No. .....

1. PLACE OF DEATH.

County of Bear Lake
City of Montpelier.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph M. Young.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.: March (Month) 20 (Day) 1891 (Year)

7. AGE: 25 Yrs. 8 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Maryland

10. NAME OF FATHER: Brigham Young jr.

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Helen Armstrong

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. J. Edmunds
(Address) Wales, Utah.

15. Filed 12/31 1916. H. H. King Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 14 1916, to Dec 16 1916, that I last saw him alive on Dec. 16 1916, and that death occured on the date stated above, at 2:20A M.

The CAUSE OF DEATH* was as follows:
Appendicitis

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Gun Shot Wound, Abdoman

(Duration) 0 yrs. 6 mos. ..... ds.

(Signed) Jas. F. Oakley M. D.

12.16.16 (Address) Montpelier, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos....2days. In the State.....yrs.3..mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Salt Lake City, Utah.

19. PLACE OF BURIAL OR REMOVAL: Ephraim, Utah. | DATE OF BURIAL: Dec. 20 1916

20. UNDERTAKER: F. M. Williams | ADDRESS: Montpelier, Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16285
Registered No.

1. PLACE OF DEATH
County of Elmore
City of Elmo's Ferry
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 35
Primary Registration District No. 2021
(No. ....., ... St.)

2. FULL NAME Harvey Bond

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 11 (Day) 1915 (Year)

7. AGE: 1 yrs. 9 mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Joseph Bond

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Exie Adams

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Bond
(Address) Elmo's Ferry Idaho

15.
Filed Dec. 7th 1916 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 6th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 4th 1916, to Dec. 6th 1916
that I last saw him alive on Dec. 5th 1916,
and that death occurred on the date stated above, at 2:05 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia

..... (Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) Extensive Burn on neck & shoulder and left leg
..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. W. Davis M. D.
Dec. 7th 1916 (Address) Elmo's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Joseph Bond Elmo's Ferry Ida — DATE OF BURIAL: Dec. 8th 1916

20. UNDERTAKER: Joseph Bond — ADDRESS: Elmo's Ferry Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

U. S. No. 5-15 M. 1-16-13

CERTIFICATE OF DEATH. 16286

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 63
Registered No. 16286

1. PLACE OF DEATH.
County of Blaine
City of Ames
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 59
Primary Registration District No. 21139
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dean Andreason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
(Month) 1 (Day) 9 (Year) 15

7. AGE
..... Yrs. 17 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Monroe, Utah

10. NAME OF FATHER Lewis Andreason

11. BIRTHPLACE OF FATHER
(State or Country) Ephraim, Utah

12. MAIDEN NAME OF MOTHER Jenn Allred

13. BIRTHPLACE OF MOTHER
(State or Country) Spring City, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. L. Buchanan
(Address) Ames, Idaho

15.
Filed 12/14 1916
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
12 (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/12/1916, to 12/12 1916, that I last saw him alive on 12/12 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Measles
(Duration ..... yrs. ..... mos. 7 ds.

(Signed) [illegible] M. D.
12/14 1916 (Address) Ames, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ames Idaho — DATE OF BURIAL: 12/14 1916

20. UNDERTAKER: A. L. Buchanan — ADDRESS: Ames Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2139
(No. ....., ... St.)

File No. 65
Registered No. 16287

1. PLACE OF DEATH.
County of Blaine
City of Arco

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Delma Viola Stoddard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 9 (Day) 1916 (Year)

7. AGE: ..... Yrs. 5 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Arco Idaho

10. NAME OF FATHER: Charles Stoddard

11. BIRTHPLACE OF FATHER (State or Country): Tyrone, Utah

12. MAIDEN NAME OF MOTHER: Lena McCarley

13. BIRTHPLACE OF MOTHER (State or Country): Savannah Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Charles Stoddard
(Address): Arco, Idaho

15. Filed 12/20 1916 — Ewfox, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1916, to Dec 22 1916, that I last saw her alive on 12/22-16 1916, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

12/22 1916 (Signed) Ewfox M. D.
(Address) Arco, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arco Idaho
DATE OF BURIAL: 12/22 1916

20. UNDERTAKER: John McCarley
ADDRESS: Arco

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Hove
(No. ..... St.)

Registration District No. 59
Primary Registration District No. 3139

File No. 64
Registered No. 16288

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruben Edward Fallert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Aug (Month) 29 (Day) 1914 (Year)

7. AGE
2 Yrs. 2 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Hove, Idaho

10. NAME OF FATHER: Lorenz Fallert

11. BIRTHPLACE OF FATHER
(State or Country) Gadenbachen, Germany

12. MAIDEN NAME OF MOTHER: Rose L. Gilson

13. BIRTHPLACE OF MOTHER
(State or Country) Paradise, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Rose Fallert
(Address) Hove, Idaho

15.
Filed Nov 6 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1916, to Nov 5 1916, that I last saw h. i. alive on Nov 5 1916, and that death occured on the date stated above, at 29 M.

The CAUSE OF DEATH* was as follows:
Diarrhea & enteritis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
11/6 1916 (Address) Hove, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hove, Idaho
DATE OF BURIAL: 11/6 1916

20. UNDERTAKER: Lorenz Fallert
ADDRESS: Hove, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Blaine

City of Ares

Registration District No. 59

Primary Registration District No. 2139

(No. ....., ... St.)

File No. 62

Registered No. 16289

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Theresa Miel Black

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 28 (Day) 1875 (Year)

7. AGE: 40 Yrs. 11 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Summit Co. Utah

10. NAME OF FATHER: John A. Miel

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Emilia Stevens

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Parley P. Black

(Address) Ares, Idaho

15.

Filed Nov 25 1916

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1916, to Nov 24 1916, that I last saw h alive on Nov 24 1916, and that death occured on the date stated above, at 3:00 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of left Breast

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr Fox M. D.

Nov 25 1916 (Address) Ares, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? Ares, Idaho

Former or usual residence Salt Lake City, Utah

19. PLACE OF BURIAL OR REMOVAL: Ares, Idaho — DATE OF BURIAL: Nov 26 1916

20. UNDERTAKER: F. Liberne — ADDRESS: Ares, Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2139
(No. ....., ... St.)

File No. 61
Registered No. 16290

1. PLACE OF DEATH.
County of Blaine
City of Moore

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wolfred Burgman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Nov (Month) 20 (Day) 1916 (Year)

7. AGE
..... Yrs. ..... Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Moore, Idaho

10. NAME OF FATHER Wolfred Burgman

11. BIRTHPLACE OF FATHER
(State or Country) Sweden

12. MAIDEN NAME OF MOTHER Sophie Bunstedt

13. BIRTHPLACE OF MOTHER
(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wolfred Burgman
(Address) Moore, Idaho

15.
Filed Dec 1st 1916 Ewfox
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
No medical attendance.
7 mos. baby.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moore, Idaho — DATE OF BURIAL: Nov 29 1916

20. UNDERTAKER: Wolfred Burgman — ADDRESS: Moore, Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7

Primary Registration District No. 1 0 0 6

File No. 16291

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Nampa (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julia Luque

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fem	white	

6. DATE OF BIRTH. Dec (Month) 13 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 1½ ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... —

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Nampa Ida

10. NAME OF FATHER John Luque

11. BIRTHPLACE OF FATHER (State or Country) France

12. MAIDEN NAME OF MOTHER Mary Jayo

13. BIRTHPLACE OF MOTHER (State or Country) Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Luque

(Address) .....

15. Filed Dec 15 1916 Anna Hatfield Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1916, to Dec 14 1916, that I last saw her alive on Dec 14 1916, and that death occured on the date stated above, at 10:30 P M.

The CAUSE OF DEATH* was as follows:

Premature birth

6½ months gestation

(Duration) ..... Yrs. ..... mos. 36 hrs ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Murray M. D.

12/15 1916 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Catholic Cemetery	12-15 1916
20. UNDERTAKER	ADDRESS
Fred K Robinson	Nampa Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1005
File No. 16292
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lena Valdora Conklin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write the word.*): Single

6. DATE OF BIRTH: Dec (Month) 12th (Day) 1916 (Year)

7. AGE: X yrs. — mos. 10 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Servant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nampa Ida.

10. NAME OF FATHER: Albert Conklin

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Fannie Carlon

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X Albert Conklin
(Address) Nampa Ida. 1112-3rd St. N

15.
Filed Dec 22 1916 Anna Hatfield
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 22nd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-17 1916, to 12-20 1916 that I last saw h[illegible] alive on 12-20 1916 and that death occurred on the date stated above, at 4:30 A M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. McLean M. D.
12/22 1916 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn — DATE OF BURIAL: Dec 22 1916

20. UNDERTAKER: Nance — ADDRESS: —

ment of OCCUPATION is very important. See instructions on back of certificate.

Statistical purposes only. It may be properly classified. Entire blank

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 16293
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mabel Azevedo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 3 (Day) 1914 (Year)

7. AGE: 2 Yrs. 7 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Antone Azevedo

11. BIRTHPLACE OF FATHER (State or Country) Portugal

12. MAIDEN NAME OF MOTHER Isobel Egelia

13. BIRTHPLACE OF MOTHER (State or Country) Portugal

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Gilmore
(Address) .....

15. Filed Dec 28 1916 Anna Warfield Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1916, to Dec 27 1916, that I last saw her alive on Dec 27 1916, and that death occured on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:
Pneumonia -

(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Heart lesion
(Duration all her life yrs. mos. ds.
(Signed) J. P. Murray M. D.
12/28 1916 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Catholic Cem Nampa — DATE OF BURIAL: 12-28 1917

20. UNDERTAKER: Chas K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 2006

File No. 16291

County of Canyon

City of Nampa (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francis Amelia Lowe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. May (~~Dec.~~) 6 (~~16~~) 1849 (~~1916~~)
(Month) (Day) (Year)

7. AGE: 67 Yrs. 7 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Africa

10. NAME OF FATHER: Eli Wiggill

11. BIRTHPLACE OF FATHER (State or Country) ~~Africa~~ England

12. MAIDEN NAME OF MOTHER: Susan Bently

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James L. Lowe
(Address) Nampa

15. Filed Dec 20 1916 Anna Hatfield
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

N. B.—Every item of information should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1916, to Dec 16 1916, that I last saw h[illegible] alive on Dec 16 1916, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Broncho-pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Chronic Valvular Heart Disease
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Eaton M. D.
Dec 1916 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho
DATE OF BURIAL: 12/20/1916

20. UNDERTAKER: Fred Robinson
ADDRESS: Nampa Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 16295
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Murrel Hagler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 1 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Clarence Hagler

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Francis E. Humphrey

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Clarence Hagler.
(Address) Nampa Ida

15. Filed Dec 21 1916 Anna Hayes Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/16 1916, to 12/20 1916, that I last saw him alive on 12/20 1916, and that death occured on the date stated above, at 1. P. M.

The CAUSE OF DEATH* was as follows:
Pleurisy with acute
Endocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute follicular tonsilitis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. G. Robinson M. D.
12/22 1916. (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: 12-21 1916

20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa

N. B.—Every question must be answered in plain terms, so that it may be properly classified. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1006
Primary Registration District No.
File No. 16296
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis McCoshum

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov (Month) 29 (Day) 1915 (Year)

7. AGE: 1 Yrs. 1 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: /
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER W. H. McCoshum

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Mamie Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W H McCoshum
(Address)

15. Filed Dec 28 1916 Anna Hayes Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 27th 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/11/1916, to 12/27/1916, that I last saw him alive on 12/24/1916, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Acute Broncho-Pneumonia.

(Duration) 0 Yrs. 0 mos. 14 ds.
Contributory (Secondary) Nephritis
(Duration unknown. yrs. mos. ds.
(Signed) Geo. A. Kellogg M. D.
12/28 1916 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn — DATE OF BURIAL: Dec 28 1916

UNDERTAKER: F R Robinson — ADDRESS: Nampa Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 1006

File No. 16297

County of Canyon

City of Nampa (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Morrison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fem

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.):

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1907 (Year)

7. AGE: 9 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. In school
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. E. Morrison

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Belle Hawkins

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John E. Morrison
(Address) Nampa Idaho

15. Filed Dec 23 1916 Anna Haefner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1916, to Dec 21 1916, that I last saw her alive on Dec 21 1916, and that death occured on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) La Grippe
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. H. Murray M. D.
12/21/1916 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida

DATE OF BURIAL: 12-24 1916

20. UNDERTAKER: Fred K Robins

ADDRESS

SYMS - YORK CO., PTRS. & SORS. 24854

Should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16298

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of ..... (No. ....., ... St.)

Registration District No. 7

Primary Registration District No. 2006

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. T. Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Mar (Month) 24 (Day) 1865 (Year)

7. AGE: 51 Yrs. 2 Mos. 24 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Alabama

10. NAME OF FATHER Henry Williams

11. BIRTHPLACE OF FATHER (State or Country) Alabama

12. MAIDEN NAME OF MOTHER Dont know

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. T. Williams
(Address) Bowmont

15. Filed Jan 1 1917 Anna Hatfield Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-31 1916, to 12-31 1916, that I last saw h. alive on 12-31 1916, and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Miliary Tuberculosis
(Secondary)
(Duration) 3 Yrs. — mos. — ds.
Contributory
(Secondary)
(Duration Yrs. mos. ds.

(Signed) G. Lincoln M. D.
1/1 1917 (Address) Nampa

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho	1-1 1917
20. UNDERTAKER	ADDRESS
Frank P. Lundon	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Kendrick
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No. 2143
(No. ....., ... St.)

File No. 16299
Registered No. 37
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Franklin Durbin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH
Aug (Month) 18 (Day) 1855 (Year)

7. AGE
61 yrs. 4 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER C. B Durbin

11. BIRTHPLACE OF FATHER (State or Country) American

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy Durbin son
(Address) Roseburg Oregon

15.
Filed Dec 21 1916 J E Hoyt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1913, to Dec 20 1916, that I last saw h alive on Dec 20 1916, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Valvular disease of heart & acute nephritis

..... (Duration) ..... yrs. ..... mos. 2 ds.
Contributory Chronic Nephritis
(Secondary) & Valvular disease of heart
..... (Duration) 20 yrs. — mos. ..... ds.
(Signed) J. E. Hoyt M. D.
12 20 1916 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Kendrick cemetery
DATE OF BURIAL: 12 23 1916

20. UNDERTAKER: E E Bechtal
ADDRESS: Kendrick Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16300

Registered No. 26

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon Co

Primary Registration District No. 2007

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha J Reed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
F	W.	Wid (Write the word.)

6. DATE OF BIRTH: May (Month) 20 (Day) 1843 (Year)

7. AGE: 73 yrs. 6 mos. 14 ds.

IF LESS than 1 day how many .....hrs. or .....mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Tenn

10. NAME OF FATHER Wm Lamarr

11. BIRTHPLACE OF FATHER (State or Country) Do not Know

12. MAIDEN NAME OF MOTHER Do not Know

13. BIRTHPLACE OF MOTHER (State or Country) Do not Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J C B Reed
(Address) .....

15. Filed Dec. 7 1916 Lulu Caldwell Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1916, to Dec 4 1916, that I last saw her alive on Dec 3 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) — yrs. — mos. 4 ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. B. Allen M. D.

12-4 1916 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nyssa — DATE OF BURIAL: .....191..

20. UNDERTAKER: Peckham Casket — ADDRESS: Parma

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form 1. Rev. 1916

CERTIFICATE OF DEATH

Registration District No. 720 1/4

County of Idaho

City of Grangeville (No. ....., ... St.) Registered No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily Francis Bateman

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: Feb. (Month) 1 (Day) 1853 (Year)

7. AGE: 63 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Hodson Bickford.

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Alberta Holmes
(Address) Grangeville

15. Filed Jan 5 1917 G B Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 5th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1916, to Dec 5 1916, that I last saw h~~er~~ ~~alive~~ on Dec 5 1916, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Strychnine Poisoning
accidentally ingested

(Duration) 20 minutes yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. N. Spencer M. D.
12/6 1916 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt Idaho — DATE OF BURIAL: Dec 7 1916

20. UNDERTAKER: A. J. Maugg — ADDRESS: Grangeville Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

County of Idaho

Primary Registration District No. 2181

City of Whitebird (No. ....., ... St.)

File No. 16302

Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maud Anna Daly.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: March (Month) 17 (Day) 1878 (Year)

7. AGE: 37 yrs. 8 mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: Milton F. Brunegar

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Lydia Stucker

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Millard Daly
(Address) Whitebird

15. Filed Jan 5 1917 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1916, to Dec 11 1916, that I last saw her alive on Dec 11 1916, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Shock following operation for Ruptured Tutat Ectopic Pregnancy

(Duration) ..... yrs. ..... mos. 1/4 ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Stinson M. D.

11/13 1916 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho. DATE OF BURIAL: Dec 14 1916

20. UNDERTAKER: A. J. Mauzy ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 88
Primary Registration District No. 2164
(No. ....., ... St.)

File No. 16304
Registered No. .....

1. PLACE OF DEATH.
County of Washington
City of Cambridge

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Edward Gibbs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 17 (Month) 25 (Day) 1876 (Year)

7. AGE: 46 Yrs. 6 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: A J Gibbs

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Anna E Dalton

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anna E Jewell
(Address) .....

15. Filed June 1 1916. O O Schuett Local Registrar

SYMS-YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Suicide with
revolver.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanitary

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr. C. E. Schuett M. D.
19..... (Address) Cambridge Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida. DATE OF BURIAL: ..... 191...

20. UNDERTAKER: James Hudelson ADDRESS: Cambridge Ida

FORM V. S. No. 5-15 M. 1-16-13

CERTIFICATE OF DEATH.

State of [redacted]
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Washington Co

City of Cambridge

Registration District No. 88

Primary Registration District No. 2164

(No. ....., ... St.)

File No. 16305

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Anderson Marquess

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.

Apr (Month) 14 (Day) 1864 (Year)

7. AGE

62 Yrs. 7 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER Samuel Marquess

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Hulda Christ

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J A Marquess

(Address) .....

15.

Filed Jan 1 1916 C O Schmutz Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 10 (Day) 1915 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs.....mos.....ds.

(Signed).....M. D.

.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Md

DATE OF BURIAL: 12/12 1915

20. UNDERTAKER: J A Anderson

ADDRESS: Cambridge

of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 88

Primary Registration District No. 2164

File No. 16306

County of

City of

(No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur J. Moss

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 16 (Day) 1847 (Year)

7. AGE 69 Yrs. 2 Mos. 30 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Prospector
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER L B Moss

11. BIRTHPLACE OF FATHER (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER Ora Minor

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jas Moss
(Address) .....

15. Filed Dec 16 1916 C C Schmitt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1916, to Dec 15 1916, that I last saw him alive on Dec 14 1916, and that death occured on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Dysentery

(Duration) ..... Yrs. ..... mos. 7 ds.

(Signed) C C Schmitt M. D.

Dec 16 1916. (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho | DATE OF BURIAL: Dec 16 1916

20. UNDERTAKER: Jas Heidelaun | ADDRESS: Cambridge Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16307

Registered No. .....

1. PLACE OF DEATH.

County of Washington Registration District No. 88

City of Cambridge Primary Registration District No. 2164

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ward G Edwards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Apr (Month) ..... (Day) 1840 (Year)

7. AGE: 76 Yrs. 8 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): South Wales

10. NAME OF FATHER: George Edwards

11. BIRTHPLACE OF FATHER (State or Country): South Wales

12. MAIDEN NAME OF MOTHER: [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. E. Edwards

(Address) Cambridge Ida

15. Filed Dec 1 1916 C E Schmuck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1916, to Dec 16 1916, that I last saw him alive on Dec 16 1916, and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 1 Yrs. 3 mos. 20 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge — DATE OF BURIAL: Dec 17 1916

20. UNDERTAKER: J A Anderson — ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 88
Primary Registration District No. 2164
(No. ....., ... St.)

File No. 16308
Registered No. .....

1. PLACE OF DEATH.
County of Washington
City of Cambridge
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Missie S. Kulick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH.
April (Month) 20 (Day) 1883 (Year)

7. AGE
33 Yrs. 8 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Iowa

10. NAME OF FATHER: William D. Simmons

11. BIRTHPLACE OF FATHER
(State or Country) Missouri

12. MAIDEN NAME OF MOTHER: Lucinda K. Lockridge

13. BIRTHPLACE OF MOTHER
(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Kulick
(Address) Crane Idaho

15.
Filed Dec 25 1916 C. E. Schmutz M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1916 to Dec 24 1916, that I last saw h alive on Dec 24 1916, and that death occured on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Schmutz M. D.
Dec 25 1916 (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Midvale
DATE OF BURIAL: Dec 25 1916

20. UNDERTAKER: James Hudelson
ADDRESS: Cambridge Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 13
Primary Registration District No. 2140
File No. 16310
Registered No. 132

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ... Chas Lovell ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Marshall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. (Month) 17 (Day) 1916 (Year)

7. AGE ... Yrs. 1 Mos. 14 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None.
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Michial Marshall

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Gertrude Fenner J.

13. BIRTHPLACE OF MOTHER (State or Country) Nebr

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. N. Marshall
(Address) Idaho Falls.

15. Filed 1/6 1917 [signature] Local Registrar

SYMS - YORK CO. PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-30 1916, to 12/31 1916, that I last saw him alive on 12/31 1916, and that death occured on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Transition
...
...
...
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) ...
(Duration ... yrs. ... mos. ... ds.
(Signed) Dr. Chas E. Rogers M. D.
19... (Address) ...

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Rose Hill
DATE OF BURIAL: Jan 1917

20. UNDERTAKER: G. H. Hunt
ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16311
Registered No. 131

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls
(No. ....., ... St.)
Registration District No. 93
Primary Registration District No. 2170

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eugene Madison Sutton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child
6. DATE OF BIRTH. Sep 7 1916 (Month) (Day) (Year)
7. AGE ..... Yrs. 7 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Idaho
10. NAME OF FATHER Claude Sutton
11. BIRTHPLACE OF FATHER (State or Country) Ind
12. MAIDEN NAME OF MOTHER Anna Hurst
13. BIRTHPLACE OF MOTHER (State or Country) Ind
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Claude Sutton
(Address) Ida Falls R.D. 6
15. Filed Jan 2 1917 [signature] Local Registrar

BYRD-RICHARDSON-TORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 18 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h.....alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was, as follows:
Pneumonia
No medical attendance
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
1/2/1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 12/20 1916
20. UNDERTAKER: C E Dunwoody — ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16312

Registered No. 130

1. PLACE OF DEATH.

County of Bannock

City of Ammon

Registration District No. 73

Primary Registration District No. 2150

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leland I Shurtliff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH. June (Month) 26 (Day) 1915 (Year)

7. AGE 1 Yrs. 5 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... —

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Thomas I Shurtliff

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Marrie Mayfield

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C E Dunwoody

(Address) Ida Dale

15. Filed Jan 2 1917 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1916, to Dec 19 1916, that I last saw him alive on Dec 19 1916, and that death occured on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G H Pendleton M. D.

Dec 20 1916 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Iona Ida — DATE OF BURIAL 12/20 1916

20. UNDERTAKER C E Dunwoody — ADDRESS Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRON-YORK CO., PTRS. & BKBS. 24653

Dr Pendleton

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16313

Registered No. 129

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13

Primary Registration District No. 2107

(No. ..... St.)

2. FULL NAME Loral T. Shurtliff

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Sept 7 1913 (Month) (Day) (Year)

7. AGE: 3 Yrs. 3 Mos. 16 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Thomas Shurtliff

11. BIRTHPLACE OF FATHER (State or Country) ~~Utah~~ Idaho

12. MAIDEN NAME OF MOTHER Mamie McSmith

13. BIRTHPLACE OF MOTHER (State or Country) Iona, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C E Dunwoody

(Address) Ida Falls

15. Filed Jan 2 1917 Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 17 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1916, to Dec 17 1916, that I last saw him alive on Dec 17 1916, and that death occured on the date stated above, at 9.30P M.

The CAUSE OF DEATH* was as follows:

Measles

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J W Pendleton M. D.

12-30 1916 (Address) Idaho Falls, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Iona, Ida — DATE OF BURIAL: 12/20 1916

20. UNDERTAKER: C E Dunwoody — ADDRESS: Ida Falls

Dr Pendleton

FORM V. S. No. [illegible] M. 1-19-15

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 73
County of Bingham
Primary Registration District No. 2173
City of Idaho Falls (No. ..... St.)
File No. 1606
Registered No. 126

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas A Robson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH.
Oct (Month) 11 (Day) 1836 (Year)

7. AGE
80 Yrs. 7 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER James Robson

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Imise

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David Robson
(Address) Ida Falls

15.
Filed Jan 2 1917
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1916, to Dec 26 1916, that I last saw him alive on Dec 25 1916, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 18 ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
Dec 31 1916 (Address) Ida. Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls Ida	12/28 1916

20. UNDERTAKER C E Dinwoody | ADDRESS Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DeCline

SYRACUSE-YORK CO., PTRS. & BKBS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16315

Registered No. 127

1. PLACE OF DEATH.

Registration District No. 73

Primary Registration District No. 2111

County of Bannock

City of Ida Falls (No. Residence East of town St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vera May Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Child

6. DATE OF BIRTH. April (Month) 2 (Day) 1916 (Year)

7. AGE. 0 Yrs. 8 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho Falls

10. NAME OF FATHER Leonard Hill

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Ida F Lobraun

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leonard Hill

(Address) Ida Falls

15. Filed Jan 2 1917 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1916, to Dec 22 1916, that I last saw her alive on Dec 22 1916 and that death occured on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) J. S. Fuller M. D.

19..... (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Ucon, Ida — DATE OF BURIAL 12/26 1916

20. UNDERTAKER C E Dunwoody — ADDRESS Ida Falls

Dr Fuller

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTGS. & ENGS. 24655

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2107
File No. 16317
Registered No. 124

1. PLACE OF DEATH.
County of Bannock
City of Ida Falls
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James C Holst.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
? (Month) ? (Day) 1881 (Year)

7. AGE
35 Yrs. ? Mos. ? ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Denmark

10. NAME OF FATHER: Christian Holst

11. BIRTHPLACE OF FATHER
(State or Country) Denmark

12. MAIDEN NAME OF MOTHER: Katrine Gudiksoon

13. BIRTHPLACE OF MOTHER
(State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A C Christensen
(Address) Ucon, Ida

15.
Filed Jan 2 1917 J E Cooper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 8th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1916, to Dec 8 1916, that I last saw h— alive on Dec 8 1916, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S S Fuller M. D.
19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ucon Ida — DATE OF BURIAL: 12/11 1916

20. UNDERTAKER: C C Dunwoody — ADDRESS: Ida Falls

Dr Fuller

STAR-BOOK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2108
File No. 16319
Registered No. 123

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls, Ida
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rasmus Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 27 (Day) 1836 (Year)

7. AGE: 79 Yrs. 11 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE. (State or Country) Denmark

10. NAME OF FATHER: Nels Rasmussen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Mary Bartel

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C E Dinwoodey
(Address) Idaho Falls

15. Filed Jan 2 1917
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 15th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1911, to Jan 14 1916, that I last saw him alive on Jan 14 1916, and that death occured on the date stated above, at 9 a M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

1/2 1917 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls, Ida. DATE OF BURIAL: 1/17 1916

20. UNDERTAKER: C E Dinwoodey ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB & YORK CO., PTRS. & ENGS. 24653

Dr. Kinard

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 16320
Registered No. 122

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christina Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 9. (Day) 1837 (Year)

7. AGE: 79 Yrs. 5 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: ? Anderson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C E Dinwoodey
(Address) Ida Falls

15. Filed Jan 2 1917 C. A. Hansen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1916, to Dec 17 1916, that I last saw her alive on Dec 10 1916, and that death occured on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows: Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) C A Hansen M. D.
1/2 1917 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls, Ida — DATE OF BURIAL: 12/17 1916

20. UNDERTAKER: C E Dinwoodey — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Dr Hansen

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2102
(No. ..... , ... St.)

File No. 16321
Registered No. 126

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Floyd Lattimer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Mar. (Day) 26 (Year) 1916

7. AGE: Yrs. ..... Mos. 17 ds. .....
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Floyd Lattimer

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Viola Gray

13. BIRTHPLACE OF MOTHER (State or Country) Okla.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Floyd Lattimer
(Address) .....

15. Filed 12/26 1916 Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16th 191.., to Dec 19th 1916, that I last saw h.. alive on Dec 19th 1916, and that death occured on the date stated above, at 4 P.M.
Dec 20th 1916
The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... mos. ..... ds.

(Signed) J. C. Hollister M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: 12/16 1916

20. UNDERTAKER: G. H. Hunt — ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 73

Primary Registration District No. 2150

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16322

Registered No. 120

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E Flake

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. — (Month) — (Day) 1 (Year)

7. AGE: 53 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ky

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Joseph Steel

12. MAIDEN NAME OF MOTHER: Mary Brown

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Dan Flake

(Address) Idaho Falls

15. Filed 12/26 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 20 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1916, to Dec 19th 1916, that I last saw her alive on Dec 19th 1916, and that death occured on the date stated above, at 4a M. Dec 20 1916.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) P. L. Hollister M. D.

19..... (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: 12/22 1916

20. UNDERTAKER: G F Hunt — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2102
File No. 16323
Registered No. 119

1. PLACE OF DEATH.
County of Bonneville
City of Ida Falls
(No. Fuller Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hugh McKay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) (Day) 1893 (Year)

7. AGE: 23 Yrs. ? Mos. ? ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: R. A. McKay

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Eliza Davis

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. A. McKay
(Address) Chuckey Tenn

15. Filed Jan 26 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13, 1916, to Dec 24, 1916, that I last saw him alive on Dec 24 1916, and that death occured on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:
Fracture of base of Skull

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Fuller M. D.
12/26 1916 (Address) Ida Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Greenville Tenn. DATE OF BURIAL: 191

20. UNDERTAKER: E. E. Dunwoody ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16324
Registered No. 114

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. 710, Omeida St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13
Primary Registration District No. 2107

2. FULL NAME Lewis J. Lemmons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH.
May (Month) 20 (Day) 1915 (Year)

7. AGE
1 Yrs. 6 Mos. 21 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Denver, Colo.

10. NAME OF FATHER J. Lemmons

11. BIRTHPLACE OF FATHER
(State or Country) Mo.

12. MAIDEN NAME OF MOTHER Florence May Nelson

13. BIRTHPLACE OF MOTHER
(State or Country) Denver

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. J. Lemmons
(Address) Idaho Falls, Ida

15.
Filed 12/19 1916
E. C. Cummard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1916, to Dec 11 1916, that I last saw him alive on Dec 11 1916, and that death occured on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

.....(Duration) .....Yrs. .....mos. 1 ds.

Contributory (Secondary)

.....(Duration .....yrs. .....mos. .....ds.

(Signed) Dr. Cline M. D.

Dec 13 1916 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: 12/13 1916

20. UNDERTAKER: E. E. Dunwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

6Y48 - YORK CO., PTRS. 2 SHTS. 24658

Dr Cline.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16325
Registered No. 117

Registration District No. 73
Primary Registration District No. 2107
(No. ....., ..., St.)

If death occurs in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bannock
City of Ida Falls (Dona)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Walter Lindholm

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. July (~~Dec~~) 5 (~~4~~) 1905
(Month) (Day) (Year)

7. AGE: 11 Yrs. 5 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Albert Lindholm

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sarah Adams

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert Lindholm
(Address) Dona, Ida

15. Filed 12/19 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 4 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1916, to Dec 4 1916, that I last saw him alive on Dec 4 1916, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary)

.....(Duration .....Yrs. .....mos. .....ds.

(Signed) P. C. Hollister M. D.

19..... (Address) Ida Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls
DATE OF BURIAL: 12/6 1916

20. UNDERTAKER: E E Dunwoody
ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24853

Dr Hollister

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16326

Registered No. 116

1. PLACE OF DEATH.

County of Bonneville

City of ~~Idaho Falls~~ Iona (No. ....., ... St.)

Registration District No. 73

Primary Registration District No. 2 1 1 D

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jos. A Rawberry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.

Apr. (Month) 11 (Day) 1846 (Year)

7. AGE

70 Yrs. 8 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER John Rawberry

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Eliza Barber

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rawberry - D

(Address) Iona, Idy

15.

Filed Dec 19 1916 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 14th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1914, to Nov 1916, that I last saw him alive on Nov 1916, and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) D W Pendleton M. D.

12-19 1916 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence ..... Ship.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Poole, Ut.	12/19 1916
20. UNDERTAKER	ADDRESS
C E Dinwoodey	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16327
Registered No. 1116

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ..., Ridge ave St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2107

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marie R Shank

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feby (Month) 14 (Day) 189x (Year)

7. AGE: 24 Yrs. 10 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: Martin Reese

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) T. B. Shank
(Address) Idaho Falls

15. Filed 12/19 1916 — Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7th 1916, to Dec 16th 1916, that I last saw her alive on Dec 15th 1916, and that death occured on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... mos. ... ds.

(Signed) L. Hollister M. D.

19.... (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence: Idaho

19. PLACE OF BURIAL OR REMOVAL: Howard, Pa — DATE OF BURIAL: 12/17 1916

20. UNDERTAKER: E G Linwood — ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia

City of Malta

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 119

Primary Registration District No.

(No. , St.)

File No. 16328

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roberta Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 17 (Day) 1916 (Year)

7. AGE: — yrs. — mos. — ds.

IF LESS than 1 day how many 4 1/2 hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None – Infant

(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malta, Idaho,

10. NAME OF FATHER: Miles Francis Hall

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Elizabeth Weke

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miles Francis Hall

(Address) Malta, Idaho.

15. Filed Jan 1 1917 C. J. Sater Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17 1916, to Nov 17 1916, that I last saw her alive on Nov 17 1916, and that death occurred on the date stated above, at 5:40 P.M.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) — yrs. — mos. — ds.

Contributory (Secondary)

(Duration) 0 — yrs. — mos. — ds.

(Signed) C. J. Sater M. D.

Nov 2/1916 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 4 1/2 hrs ..yrs..mos..days. In the State 4 1/2 hrs ..yrs..mos..days.

Where was disease contracted if not at place of death? —

Former or usual residence None

19. PLACE OF BURIAL OR REMOVAL: Elba – Idaho — DATE OF BURIAL: Nov 19 1916

20. UNDERTAKER: None — ADDRESS: —

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah — Registration District No. 65

City of Potlatch — Primary Registration District No. 2145

(No. ....., ... St.)

File No. 16329

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lois Inwalds

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female.	White	Single

6. DATE OF BIRTH

Aug. (Month) 1 (Day) 1914 (Year)

7. AGE

..... yrs. 2 mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... None.

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Lloyd. Inwalds

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Elizabeth M. Farling.

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E R. Welch.

(Address) Potlatch

15.

Filed Dec. 30 1916 D. J. W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191..., to ✓ 191..., that I last saw h ✓ alive on ✓ 191..., and that death occurred on the date stated above, at 1 M.

The CAUSE OF DEATH* was as follows:

Was found dead in bed.

Unknown.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Thompson M. D.

Dec 30 1916 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Greenhall Cemetery	Dec. 30 1916
20. UNDERTAKER	**ADDRESS**
E Anderson	Potlatch Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 32

Primary Registration District No. 2019

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16330

Registered No. .....

1. PLACE OF DEATH
County of Lakeside
City of Bovill

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sam Shamrock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) 1 (Day) 1888 (Year)

7. AGE: 28 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Alex Shamrock

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alex Lazarich
(Address) Bovill

15. Filed Dec. 29 1916 — H Hunt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
December - 28 - 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1916, to Dec 28 - 1916, that I last saw him alive on Dec 28 - 1916, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Accidental Injury and Internal hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F E Gibson M. D.

12/29/1916 (Address) Bovill, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 12/30 1916

20. UNDERTAKER: H E Hunt — ADDRESS: S M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16331

Registered No. .....

1. PLACE OF DEATH.

County of Benewah

City of Tensawood

Registration District No. 92

Primary Registration District No. 2049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Allen Owen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dont Know (Month) (Day) 1895 (Year)

7. AGE: 31 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Dont Know

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C J Kinnebrew

(Address) St Maries

15. Filed Dec. 29 1916. H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

accidently killed by limb from falling tree while cutting logs in woods.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C J Kinnebrew Co Coron M. D.

19.... (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 12/1/2 1917

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16332

Registered No. .....

1. PLACE OF DEATH.

County of Shoshone

City of Stetson

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. Gilman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE about 30 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Don't Know

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Dec. 28 1916 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Struck by Train

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Mowrey Coroner M. D.

19.... (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Maries	12/30 1916
20. UNDERTAKER	**ADDRESS**
H E Hunt	S M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16333

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Benewah

City of St Maries

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dale E Maurer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. May (Month) 31 (Day) 1915 (Year)

7. AGE: 1 Yrs. 6 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: Harry Maurer

11. BIRTHPLACE OF FATHER (State or Country): Kansas.

12. MAIDEN NAME OF MOTHER: Goldie Berry

13. BIRTHPLACE OF MOTHER (State or Country): Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Maurer

(Address) St Maries

15. Filed Dec. 22 1916 — H E Hunt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1916, to Dec 22 1916, that I last saw h wife alive on Dec 21 1916, and that death occured on the date stated above, at 5-40 A.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Cornwall M. D.

Dec 22 1916. (Address) St Maries Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 12/23 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 3-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 16334
Registered No. .....

1. PLACE OF DEATH.
County of Benewah
City of St Maries
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John A Jarman

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Oct. (Month) 12 (Day) 1903 (Year)

7. AGE
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mont.

10. NAME OF FATHER James S Jarman

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Luka J Wilkie

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Jarman
(Address) St Maries

15.
Filed Dec. 23 1916 H E Hunt Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1916, to 23 1916, that I last saw him alive on Dec 22 1916, and that death occured on the date stated above, at 2 p. M.

The CAUSE OF DEATH* was as follows:
Diphtheria
.....
.....
.....
(Duration) — Yrs. — mos. 14 ds.
Contributory (Secondary) Suppurating gland
(Duration ..... yrs. ..... mos. 14 ds.
(Signed) E A Field M. D.
Dec 23 1916 (Address) St. Maries, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 12/25 1916

20. UNDERTAKER: H E Hunt — ADDRESS: S M.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16335

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Ferrunwood

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 82

Primary Registration District No. 2049

(No. ....., ... St.)

2. FULL NAME Arthur Legendre

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 65 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Dont Know

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Runsdorf

(Address) St Maries

15. Filed Dec. 19 1916. H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Found dead while working
Cardiac Insufficiency,

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Runsdorf Coroner M. D.

12/19/1916. (Address) St Maries, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos,.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries | DATE OF BURIAL: 12/24 1916

20. UNDERTAKER: H E Hunt | ADDRESS: St M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16336

Registered No. .....

1. PLACE OF DEATH.

County of Benewah

City of St Maries

Registration District No. 33

Primary Registration District No. 2049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bessie Hoisington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.: Sept. (Month) 17 (Day) 1887 (Year)

7. AGE: 29 Yrs. 2 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) .....

10. NAME OF FATHER: John Denton

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: D. K.

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ray Hoisington

(Address) St Maries

15.

Filed 12/18 1916

H E Hunt
Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9th 1916, to Dec 15-th 1916, that I last saw her alive on Dec 15-th 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Primary Cause
followed by general
paralysis

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas D Platt M. D.

Dec 15 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 12/18 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. .... St.)

File No. 16337
Registered No. .....

1. PLACE OF DEATH.
County of Benewah
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Olsen.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Don't Know (Month) (Day) (Year)

7. AGE: 24 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. J. Kingsbury
(Address) City

15.
Filed 12/18 1916 H E Hunt Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1916, to Dec 18 1916, that I last saw him alive on Dec 18 1916, and that death occured on the date stated above, at 9:30 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia with
complications
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Typhoid Fever
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. J. Kingsbury M. D.
12/18 1916 (Address) St Maries, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 12/19 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16338

Registered No. .....

1. PLACE OF DEATH.

County of Benewah

City of St Maries

Registration District No. 82

Primary Registration District No. 2049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H. Dodson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 29 (Day) 1916 (Year)

7. AGE ..... Yrs. 1 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): St Maries

10. NAME OF FATHER: W. H. Dodson

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Stella Purdy

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W H Dodson

(Address) St Maries

15.

Filed 12/16 1916

H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 13 1916, to Dec 15 1916, that I last saw him alive on Dec 15 1916, and that death occured on the date stated above, at 9:10 P M.

The CAUSE OF DEATH* was as follows:

Malnutrition

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. Kinsolving M. D.

12/16 1916 (Address) St Maries.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 12/17 1916

20. UNDERTAKER: H E Hunt — ADDRESS: S M

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16339

Registered No. .....

1. PLACE OF DEATH.

County of Benewah

City of St Maries

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jack Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dont know 1 (Month) (Day) (Year)

7. AGE: about 54 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Dont know

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Kingsbury

(Address) City

15.

Filed 12/14 1916 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 14 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1915, to Dec 14 1916, that I last saw him alive on Dec 13 1916, and that death occured on the date stated above, at 5-9 M.

The CAUSE OF DEATH* was as follows:

Brights disease & Cardiac Dropsy 1

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D J Kinnaluine M. D.

12/14 1916 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 12/15 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMB - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16340

Registered No. .....

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Bennu[illegible]

City of St Maries

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James P Irwin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word!): Married

6. DATE OF BIRTH. Sept. (Month) 13 (Day) 1862 (Year)

7. AGE: 54 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: James P Irwin

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nathen S Irwin
(Address) .....

15.
Filed Dec 12 1916 H E Hunt Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 11th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21st 1916, to Dec 12th 1916, that I last saw h[illegible] alive on Dec 10th 1916, and that death occured on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:
Carcinoma in Stomach

(Duration) Yrs. about 6 mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Mullenbrook M.D.
1/12, 1916 (Address) St Maries Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 1/12 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16341

Registered No. .....

1. PLACE OF DEATH.

County of Benewah Registration District No. 32

City of St Maries Primary Registration District No. 2049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lilian Alace Burroughs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 6 (Day) 1916 (Year)

7. AGE ..... Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Geo H Burroughs

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Minnie Hagan

13. BIRTHPLACE OF MOTHER (State or Country) Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo H Burroughs

(Address) St Maries

15. Filed Dec 8 1916 H E Hunt Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5th 1916, to Dec 7 1916, that I last saw her alive on Dec 7 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C J Kinnaborine M. D.

12/7 1916 (Address) St Maries Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 12/9 1916

20. UNDERTAKER: H E Hunt — ADDRESS: St Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1634 2

Registered No. .....

1. PLACE OF DEATH.

County of Benewah — Registration District No. 32

City of St Maries — Primary Registration District No. 2049 (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Hoisington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 7 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..3.. hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): St Maries

10. NAME OF FATHER: Ray Hoisington

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Bessie Denton

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF ~~MY~~ KNOWLEDGE.

(Informant) Ray Hoisington

(Address) St Maries

15. Filed Dec 7 1916 — H E Hurst, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1916, to Dec 7 1916, that I last saw h[illegible] alive on Dec 7 1916, and that death occured on the date stated above, at 1 a M.

The CAUSE OF DEATH* was as follows:

Premature Labor
6½ months Cord
Three Days.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dora D. Call M. D.

Dec 7 1916 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 12/18 1916

20. UNDERTAKER: H E Hurst — ADDRESS: 8 M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

D.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 60
Primary Registration District No. 2129.
(No. ....., ... St.)

File No. 16343
Registered No. 13

1. PLACE OF DEATH.
County of Lewis
City of Voltmer P.O.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac C. Way

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH.
Aug (Month) 13 (Day) 1840 (Year)

7. AGE
76 Yrs. 3 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Thomas Way

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Amburn

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S. T. Way
(Address) Voltmer Ida.

15. Filed Dec 6 1916
P. E. Dwelle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
December (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1916, to Dec 4 1916, that I last saw him alive on Dec. 4 1916, and that death occured on the date stated above, at 10 a M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) Indefinate Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) E. J. Burke M. D.
12-16 1916 (Address) Voltmer Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fletcher cemetery
DATE OF BURIAL: 12/7 1916

20. UNDERTAKER: S. T. Way
ADDRESS: Voltmer Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 38

Primary Registration District No. 2086

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16344

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan (Month) 2 (Day) 1840 (Year)

7. AGE 76 Yrs. 11 Mos. [redacted] ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) N Y

10. NAME OF FATHER Joseph Taylor

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C D Taylor

(Address) Burley

15.

Filed 12-20 1916 A A Newberry Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,

that I last saw h... alive on ....., 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Found dead in toilet

Cause unknown

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. W. Schubert M. D.

12-18-1916 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Tolen Cemetery

DATE OF BURIAL .....191...

20. UNDERTAKER F E Drake

ADDRESS Filer

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 38

Primary Registration District No. 2086

State of Idaho
BOARD OF VITAL STATISTICS
Bureau of Vital Statistics

File No. 16345

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of Filer

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joel Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 4 (Day) 96 (Year)

7. AGE: ..... Yrs. 5 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Zella Carter

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs N Turnbaugh

(Address) Filer

15. Filed Dec 16 1916

A A Newberry
Local Registrar

SYMS - YORK CO., PTRS. & ROBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 23 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1916, to Dec 22 1916, that I last saw him alive on Dec 22 1916, and that death occured on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(Duration) — Yrs. — mos. 4 ds.

Contributory (Secondary) Ulcerative colitis

(Duration) — yrs. — mos. 20 ds.

(Signed) Frank A. Dwight M. D.

Dec 25 1916 (Address) Filer, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer — DATE OF BURIAL: Dec 25 1916

20. UNDERTAKER: F E Drake — ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 2086
(No. ....., ... St.)

File No. 16346
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Beulah May Pearson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W.	

6. DATE OF BIRTH
Nov. (Month) 6 (Day) 1916 (Year)

7. AGE
..... yrs. ..... mos. 43 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Filer Ida

10. NAME OF FATHER W E Pearson

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Mary Ruth Weidner

13. BIRTHPLACE OF MOTHER (State or Country) Ia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W E Pearson
(Address) Filer Ida

15.
Filed 12-20 1916 A A Newberry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1916, to Dec 20 1916, that I last saw her alive on Dec 20 1916, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A A Newberry M. D.
Dec 20 1916 (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Cemet. DATE OF BURIAL: 12-21 1916

20. UNDERTAKER: T E Drake ADDRESS: Filer Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760"

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2086
File No. 16347
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clarence Andrew Lynard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 24 1896 (Month) (Day) (Year)

7. AGE: 20 Yrs. 7 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: David M. Lynard

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Nettie Mathis

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): David Lynard
(Address): Filer Idaho

15.
Filed 12-16 1916
T A Newberry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 15 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1916, to Dec 15 1916, that I last saw h. living on Dec 15 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) D. C. Gingrich M. D.
19..... (Address) Filer Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: ~~F. E. Drake~~ Filer — DATE OF BURIAL: Dec 17 1916

20. UNDERTAKER: F. E. Drake — ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16350

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Custer

City of Mackay.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Verl Beaverland

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1 (Year)

7. AGE

.....Yrs.....Mos.....ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15.

Filed Dec 29 1916. W. D. Teegan Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 20 1916

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 12 1916, to Dec 20 1916, that I last saw h[illegible] alive on Dec 20 1916 and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

following exposure to cold

+ Pneumonia

(Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) W. D. Teegan M. D.

12/29 1916 (Address) Mackay Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191.....

20. UNDERTAKER | ADDRESS

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16351

Registered No.

1. PLACE OF DEATH.
County of Boise
City of Placerville
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.

2. FULL NAME Martin Cathcart

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): M

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1835 (Year)

7. AGE: 81 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: merchant
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Cathcart

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C B Cassard
(Address) Placerville

15. Filed Jan 6th 1917. Mrs Sadie Everett, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1916, to Dec 26 1916 that I last saw h[illegible] alive on Dec 26 1916, and that death occurred on the date stated above, at 1.30 P M.

The CAUSE OF DEATH* was as follows:
Influenza, complicated with Chronic Nephritis Arterio Sclerosis
~~Fever~~ (Duration) ..... yrs. 1 mos. ..... ds.
Contributory (Secondary) Diabetes, Paralysis,
..... (Duration) 15 yrs. ..... mos. ..... ds.
(Signed) Chas B. Cassard, M. D.
Dec 27 1916 (Address) Placerville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Placerville Ida
DATE OF BURIAL: Dec 28 1916

20. UNDERTAKER: none
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

Primary Registration District No. 2072

File No. 16352

Registered No. .....

County of Power

City of Am Falls.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Leichner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mail

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.

July (Month) 20 (Day) 1914 (Year)

7. AGE

Ans Yrs. 5 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Infant

(b) General nature of industry, business, or establishment in which employed (or employer)..... John Leichner

9. BIRTHPLACE

(State or Country) Power

10. NAME OF FATHER John Leichner

11. BIRTHPLACE OF FATHER

(State or Country) Russia

12. MAIDEN NAME OF MOTHER Tania Israel

13. BIRTHPLACE OF MOTHER

(State or Country) South Dak.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Leichner

(Address) American Falls Idaho

15.

Filed Dec 31 1916 R. F. Nott.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1916, to Dec 30 1916, that I last saw him alive on Dec 23 1916, and that death occured on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

..... (Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. E. Nott M. D.

12/31 1916 (Address) Am Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Am Falls — DATE OF BURIAL: Dec 31 1916

20. UNDERTAKER: F. Benz — ADDRESS: Am Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2072
File No. 16353
Registered No. .....

1. PLACE OF DEATH.
County of Power
City of Am Falls
(No. .... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Henry Stamper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: July (Month) 4 (Day) 1854 (Year)

7. AGE: 62 Yrs. 5 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John W Stamper

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John W Stamper
(Address) .....

15. Filed Dec 10 1916 — C F Worth, Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1916, to Dec 9 1916, that I last saw h[illegible] alive on Dec 9 1916, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Richard F Koch M. D.

12/10 1916 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weston Oregon
DATE OF BURIAL: Dec 1916

20. UNDERTAKER: H K Rogers
ADDRESS: American Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 25

Primary Registration District No. 2072

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16354

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Perwen

City of Ann Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Adams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH.

Sept (Month) 9 (Day) 1852 (Year)

7. AGE

64 Yrs. 1 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Michigen

10. NAME OF FATHER: Alanson Adams

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mary Yates

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. P. Adams

(Address) Rockland

15.

Filed Dec 2 1916 R. F. Wood Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 31st (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1916, to Nov 30 1916, that I last saw h in alive on Nov 30 1916, and that death occured on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

..... (Duration) — Yrs. — mos. 5 ds.

Contributory (Secondary) Chronic Nephritis

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Richard F Wood M. D.

1 yr 1916 (Address) Ann Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos. 8 days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? Rockland Ida.

Former or usual residence Rockland Idaho.

19. PLACE OF BURIAL OR REMOVAL: Ann Falls

DATE OF BURIAL: Dec 2 1916

20. UNDERTAKER: H P Hager

ADDRESS: Ann Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24852

FORM, V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2072
File No. 16355
Registered No. .....

1. PLACE OF DEATH.
County of Power
City of Am Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles F. Stebbins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mall
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (If married, the word): Married

6. DATE OF BIRTH.
Oct (Month) 12 (Day) 1879 (Year)

7. AGE
37 Yrs. — Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Well Driller
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Enos Stebbins

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Minnie Merrill

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. F. Stebbins
(Address) Portal N. Dak

15.
Filed Nov 16 1916
R. F. York
Local Registrar

SYMS - YORK CO., PTRS. & BNRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1916, to Nov 6 1916, that I last saw h.e alive on Nov 6 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Traumatic Amputation of right arm

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Richard F. York M. D.
11/6 1916 (Address) Am Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portal Am Falls, — DATE OF BURIAL: 11 8 1916

20. UNDERTAKER: H. R. Hagar — ADDRESS: Am Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2072
File No. 16356
Registered No. .....

1. PLACE OF DEATH.
County of Power
City of Am Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hubert Arthur Claassen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single

6. DATE OF BIRTH: Dec (Month) 12 (Day) 1911 (Year)

7. AGE: 5 Yrs. ... Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Adolph Claassen

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Mamie J Kyler

13. BIRTHPLACE OF MOTHER (State or Country): California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Adolph Claassen
(Address) Am Falls

15. Filed Dec 31 1916 R. E. Hoch Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22 1916, to Dec 28 1916, that I last saw him alive on Dec 28 1916, and that death occured on the date stated above, at 900 M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ... Yrs. ... mos. 9 ds.

Contributory (Secondary): Measles

(Duration) ... yrs. ... mos. 7 ds.

(Signed) Richard F Hoch M. D.

Dec 31 1916 (Address) Am Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Am Falls — DATE OF BURIAL: 1/3/17 1916

20. UNDERTAKER: J. R. Hagan — ADDRESS: Am Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

County of Power

Primary Registration District No. 2072

File No. 16357

City of American Falls (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William A. West

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (~~Write the word.~~)

6. DATE OF BIRTH. Oct. (Month) 19 (Day) 1862 (Year)

7. AGE: 53 Yrs. 1 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Ranches
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER Alexander West

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Elizabeth Willey

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Laura Smith
(Address) American Falls

15. Filed Dec 1 1916 R. F. Work Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1916, to Nov 26 1916, that I last saw h[illegible] alive on Nov 26 1916 and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) V. P. Lutz M. D.

12/16 1916 (Address) Rockland

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: American Falls — DATE OF BURIAL: Nov. 28 1916

20. UNDERTAKER: Larkin & Sons — ADDRESS: Pocatello

SYMS - YORK CO., PTRS. & BOXS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 2072
File No. 16358
Registered No.

1. PLACE OF DEATH.
County of Ravalli
City of Am Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME August Stalz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Baby White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Dec 15th (Month) 1916 (Day) (Year)
7. AGE: .....Yrs. 1 Mos. 1 ds. IF LESS than 1 day how many .....hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Baby
9. BIRTHPLACE (State or Country) Am. Falls Idaho
10. NAME OF FATHER August Stalz
11. BIRTHPLACE OF FATHER (State or Country) Russia
12. MAIDEN NAME OF MOTHER Christina Preszlin
13. BIRTHPLACE OF MOTHER (State or Country) Russia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) August Stalz
(Address) Am Falls Idaho
15. Filed Dec 17 1916 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 15th (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1916, to Dec 15 1916, that I last saw h[illegible] alive on Dec 15 1916 and that death occured on the date stated above, at 3 30 P.M.
The CAUSE OF DEATH* was as follows: Thrush Cause Unknown
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O J Starr M. D.
19.... (Address) Am Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sprod Butte — DATE OF BURIAL: Dec 16 1916
20. UNDERTAKER: Am Falls Idaho. — ADDRESS: Am Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2572
File No. 16359
Registered No. .....

1. PLACE OF DEATH.
County of Power
City of American Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wiley Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH. Do not know
(Month) (Day) (Year)

7. AGE 73 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Tennessee

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER (State or Country) Do not know

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. F. Schuck
(Address) American Falls Ida.

15. Filed Sept 26 1916 C F Tooke Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 24 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1916, to Sept 24 1916, that I last saw him alive on Sept 23 1916, and that death occured on the date stated above, at 2 a. M.

The CAUSE OF DEATH* was as follows:
Aortic Stenosis.
(Duration) 3 about Yrs. — mos. — ds.
Contributory (Secondary) Nephritis —
(Duration) 1 about yrs. — mos. ..... ds.

(Signed) C. F. Schuck M. D.
Sept 26 1916 (Address) American Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs. 1 mos. 10 days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? In Power Co.
Former or usual residence Power Co.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
American Falls	Sept 26 1916
20. UNDERTAKER H. R. Hager	ADDRESS American Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-15 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Power
City of .....
(No. ....., ... St.)
Registration District No. 25
Primary Registration District No. 2072
File No. 16361
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Mary Lippert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 11 (Day) 1916 (Year)

7. AGE: .....Yrs. 3 Mos. 6 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER David Lippert

11. BIRTHPLACE OF FATHER (State or Country) Russia

12. MAIDEN NAME OF MOTHER Katie Knoll

13. BIRTHPLACE OF MOTHER (State or Country) Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David Lippert
(Address) Rocky Dolphin, Idaho

15.
Filed Aug 18 1916
R. T. Hodnett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....191....., to .....191.....,
that I last saw h.....alive on .....191.....,
and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Left with mother found dead in bed next morning; no suspicion of foul play
(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....
(Duration .....yrs. .....mos. .....ds.

(Signed) C. F. Aeluck M.D.
8 18 1916 (Address) Cascade Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: German Baptist Cemetery — DATE OF BURIAL: Aug 18 1916
20. UNDERTAKER: Cascade Falls — ADDRESS: —

None

EVENS - WERK CO., PTRS. & ENGR. 24688

FORM V. S. No. 3-35 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

Registration District No. 102

Primary Registration District No. 2194

(No. ..... St.)

File No. 16362

Registered No. 101

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. J. Bligg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.

Unknown (Month) ..... 1 (Day) ..... (Year)

7. AGE

60 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Miss

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. Jon Poynter

(Address) Blackfoot Idaho

15.

Filed Nov 28 1916

M E Ellis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1916, to Nov 27 1916, that I last saw him alive on Nov 27 1916, and that death occured on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) Unknown Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. Jon Poynter M. D.

19..... (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 3 days. In the State 12 yrs.....mos.....days

Where was disease contracted if not at place of death? Blackfoot Idaho

Former or usual residence Blackfoot Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Asylum Cemetary	11/27 1916

20. UNDERTAKER	ADDRESS
G. D. Ferrell	Asylum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 1007
File No. 16363
Registered No. 102

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Jones.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 2 (Day) 1916 (Year)

7. AGE: ... Yrs. ... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Thomas Jones

11. BIRTHPLACE OF FATHER (State or Country): Colorado

12. MAIDEN NAME OF MOTHER: Edna Estella Bradley

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Thomas Jones
(Address) Blackfoot Idaho

15. Filed Dec 4th 1916 W. E. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1916, to Dec 3 1916, that I last saw h er alive on Dec 2 1916, and that death occured on the date stated above, at 10:45 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) W W Beck M. D.

12/4 1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Idaho — DATE OF BURIAL: Dec 4 1916

20. UNDERTAKER: John Thomas Jones — ADDRESS: Blackfoot Box 1865

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 1007

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16364

Registered No. 163

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wahnetta Dowdle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. (Month) 26 (Day) 1907 (Year)

7. AGE: 8 Yrs. 11 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Samuel Clark Dowdle

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Rosa Bell Williams

13. BIRTHPLACE OF MOTHER (State or Country): West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Clark Dowdle

(Address) Blackfoot PO 284

15. Filed Dec. 6 1916

W. E. Patria
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1916, to Dec 6 1916, that I last saw h.er alive on Dec 5 1916, and that death occured on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid fevers

(Duration) — Yrs. 1 mos. 10 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Beck M. D.

12/6 1916 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hyrum Utah — DATE OF BURIAL 191

20. UNDERTAKER: E. T. Beck — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ..... St.)

File No. 16365
Registered No. 1074

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham
City of Blackfoot R F D 2

2. FULL NAME Mrs Marion Crawford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widowed

6. DATE OF BIRTH. June (Month) 30 (Day) 1845 (Year)

7. AGE 71 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Tasmania

10. NAME OF FATHER Robert Mann

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Agnes ——

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wm. Crawford

(Address) Blackfoot R F D No 2

15. Filed Dec. 12 1916 M. E. Petrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1916, to Dec 11 1916, that I last saw her alive on Dec 11 1916, and that death occured on the date stated above, at 5 05 P. M.

The CAUSE OF DEATH* was as follows:

Bronchitis

..... (Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) General Debility

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jos B Davis M. D.

12-11 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Thomas-Rimrock — **DATE OF BURIAL** Dec 14 1916

20. UNDERTAKER William A Crawford — **ADDRESS** Blackfoot

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

16367

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 131
Primary Registration District No. 2194
(No. ..... St.)

File No. 46
Registered No. 105106

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter H Pyeatt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)
7. AGE: 58 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Ida
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (State or Country) Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O M Poyner
(Address) Blackfoot Ida
15. Filed Dec 20 1916 M E Fabrie Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 19 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 2/12-7 1915, to Dec 19 1916, that I last saw him alive on Dec 19 1916, and that death occured on the date stated above, at 12 30 A.M.
The CAUSE OF DEATH* was as follows:
Extension of Mouth
Disease and its pointy
(Duration) 1 Yrs. 3 mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) O M Poyner M. D.
19 ..... (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. 1 yrs. 2 mos. 22 days In the State 37 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Unknown
Former or usual residence Lonsdale Idaho Co

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
D. Cemetery	Dec 22 1916

20. UNDERTAKER	ADDRESS
J. W. Buttars	Blackfoot

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16369

Registered No. 108

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 1007

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earnest Brown

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Dec (Month) 27 (Day) 1896 (Year)

7. AGE: 25 Yrs. 10 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Frank K. Brown

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Jessie Hudson

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. F. Brown

(Address) .....

15. Filed Dec 28 1916 W. E. Price Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 6 1916, to Dec. 27 1916, that I last saw him alive on Dec. 27 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pyonephrosis

(Duration) 20 Yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

12/27 1916 (Address) F. O. Mitchell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Groveland cemetery — DATE OF BURIAL: 12 29 1916

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ..... St.)

File No. 16370
Registered No. 109

1. PLACE OF DEATH.
County of Bingham
City of Bellevue
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Price

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word): [illegible]

6. DATE OF BIRTH. Dec (Month) 14 (Day) 1916 (Year)

7. AGE ... Yrs. — Mos. 5 1/2 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: [illegible]
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chas Price

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Ora Jones

13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas Price
(Address) Bellevue Ida

15. Filed Dec 19 1916 M. E. Parish
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1916, to Dec 19 1916, that I last saw h[illegible] alive on Dec 19 1916, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Premature Birth
7 1/2 mos.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) J. B. Davis M. D.
1916 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Farm near Price Teton Ida
DATE OF BURIAL: 12-21 1916

20. UNDERTAKER acting: Chas Price
ADDRESS: Blackfoot Ida

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16371

Registered No. 116

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 121

Primary Registration District No. 2194

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gertrude M. Snodgrass

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 5 (Day) 1890 (Year)

7. AGE: 26 Yrs. ..... Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denver

10. NAME OF FATHER: Charles Welsh

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Minnie Lapp

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. C. Welsh

(Address) Elliott Iowa

15.

Filed Dec 8 1916

M. E. Gibbs
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2nd 1916, to Dec 9 1916, that I last saw h.r alive on Dec 9 1916, and that death occured on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Shock & Exhaustion following Extensive Burns

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Burns

..... (Duration ..... yrs. ..... mos. 7 ds.

(Signed) H J Summerwell M. D.

12/9 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elliott Iowa — DATE OF BURIAL: 191

20. UNDERTAKER: E. F. Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

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FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16372

Registered No. 117

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Blackfoot Bingham Registration District No. 121

City of Blackfoot Primary Registration District No. 2194

(No. West Francis St.) Blackfoot Bane Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert M. Isaac

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 5 (Day) 1909 (Year)

7. AGE: 7 Yrs. 5 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Geo. N. Isaac

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Nazie E. Martin

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Isaac

(Address) Springfield Idaho

15.

Filed Dec 10 1916

M. E. Fabric
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1916, to Dec 10 1916, that I last saw him alive on Dec 10 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Shock following gun shot wound of abdomen accidental

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) gun shot wound

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Summers M. D.

12/10 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Springfield Idaho | DATE OF BURIAL .....191.....

20. UNDERTAKER: E. F. Peck | ADDRESS Blackfoot

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 1007

(No. Blackfoot General Hospital)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16373

Registered No. 112

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Ferrell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH. Jan (Month) 12 (Day) 1896 (Year)

7. AGE 23 Yrs. 11 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER Johnson

11. BIRTHPLACE OF FATHER (State or Country) MD

12. MAIDEN NAME OF MOTHER Mckinnon

13. BIRTHPLACE OF MOTHER (State or Country) Mckinnon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wallace Ferrell

(Address) Blackfoot Idaho

15.

Filed Dec 13 1916

W E Patrick
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 30 1916, to Dec. 12 1916, that I last saw her alive on Dec. 12 1916, and that death occured on the date stated above, at 4 01 A.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage (Operation)

(Duration) Yrs. mos. 13 ds.

Contributory (Secondary) Peritonitis

(Duration) yrs. mos. ds.

(Signed) W E McLeod M. D.

12/12 1916 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL I.C. Cem. Blackfoot — **DATE OF BURIAL** Dec 14 1916

20. UNDERTAKER E J Peck — **ADDRESS** Blackfoot

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 1007

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16374

Registered No. 113

1. PLACE OF DEATH

County of Bingham

City of Blackfoot (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H Pope

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. ..... (Month) ..... (Day) ..... (Year)

7. AGE: 66 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: William M Pope.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Katherine McBride

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D L Pope

(Address) .....

15. Filed Dec 20 1916 D L Pope M E Petrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1916, to Dec 19 1916, that I last saw him alive on Dec 19 1916, and that death occured on the date stated above, at 10p M.

The CAUSE OF DEATH* was as follows:

Pneumonia - following Streptococci Infection

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Blood poisoning

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H H Swensen M. D.

12/20 1916 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Basalt Idaho — DATE OF BURIAL: Dec 21 1916

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

SYMS - YORK CO., PTRS. & BOOK. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16375

Registered No. 114

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Firth

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cornelius Vanwoerdel

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.

Mar (Month) 23 (Day) 1834 (Year)

7. AGE

82 Yrs. 8 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farming

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Livingston Co. N.Y.

10. NAME OF FATHER: Abraham Vanderdale.

11. BIRTHPLACE OF FATHER

(State or Country) Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER

(State or Country) Livingston Co. N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C E Moon

(Address) Blackfoot

15.

Filed Dec 23 1916 W. E. Tuttle

Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/12 1916, to 12/23 1916, that I last saw him alive on 12/22 1916, and that death occured on the date stated above, at 1:20 P.M.

The CAUSE OF DEATH* was as follows:

Senile debility with associated hemiplegia (Rt)

(Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Piper. M. D.

19.... (Address) Firth, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Firth, Ida

DATE OF BURIAL: 12/24 1916

20. UNDERTAKER: E J Rusk

ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 294
File No. 16376
Registered No. 15

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. Idaho Insane Asylum St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ulysses G. Joplin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7. AGE: 54 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Tom Boyne
(Address) Blackfoot Idaho

15. Filed Dec 24 1916
W. E. Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1916, to Dec 22 1916, that I last saw him alive on Dec 22 1916, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Acute Pneumonia
(Duration) Unknown Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Tom Boyne M. D.
12-23 1916 (Address) Tom Boyne

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 4 yrs. 2 mos. 17 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Unknown
Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Remains taken Charge | DATE OF BURIAL: 12/23 1916

20. UNDERTAKER: By Brown Eldridge Undertaking Co. Blackfoot, Ida. | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 16377
Registered No. 116

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hans Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7. AGE 38 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. Poyner
(Address) Blackfoot Idaho
12-26-1916

15. Filed Dec 26 1916 W. E. Parke Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1916, to Dec 26 1916, that I last saw him alive on Dec 26 1916, and that death occured on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) Unknown Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) O. Poyner M. D.
(Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 2 mos. 14 days In the State 5 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Unknown
Former or usual residence Rexburg, Idaho

19. PLACE OF BURIAL OR REMOVAL Rexburg Idaho — DATE OF BURIAL 191

20. UNDERTAKER E J Funk — ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

61

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1011
(No. 853 E. 7th St.)

File No. 16378
Registered No. 192

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carl Franklin Goff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Dec 11 1916
(Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 16 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Moscow Idaho

10. NAME OF FATHER: Simeon F. Goff

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Edith E. Shoup

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Simeon F Goff
(Address)

15. Filed Dec 28-16 1917
J. F. Ragan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec 27 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1916 to Dec 27 1916, that I last saw h[illegible] alive on Dec 27 1916, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Bronchitis.

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Ragan M. D.
Dec 28 1916 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Dec 28 1916

20. UNDERTAKER: Glen Price | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 16379
Registered No. 71

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Pauline Carlson
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 27 (Day) 1890 (Year)

7. AGE: 26 yrs. 6 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Dakota

10. NAME OF FATHER: John Johnson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Anna Weiseth

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. E. Carlson
(Address) Moscow

15. Filed Dec 18 1916 D. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11 1916 to Dec 16 1916, that I last saw h[illegible] alive on Dec 16 1916, and that death occurred on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever
(Duration) ..... yrs. 6 weeks mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Clarke M. D.
Dec 18 1916 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Dec 18 1916

20. UNDERTAKER: Glen Grice | ADDRESS: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. 218 South Polk St.)

File No. 16380
Registered No. 76
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Dec. (Month) 11 (Day) 1916 (Year)

7. AGE: ....yrs. ....mos. 3 ds.
IF LESS than 1 day how many .....*hrs. or* .....*mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Moscow Ida

10. NAME OF FATHER: Thomas Hall

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Edna Willis

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Hall
(Address) .....

15. Filed Dec 16 1916 D F Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1916, to Dec 14 1916, that I last saw him alive on Dec 14 1916, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
hypertrophic cirrhosis of Liver

.....(Duration) ....yrs. mos. 3 ds.

Contributory (Secondary) .....(Duration) ....yrs. ....mos. ....ds.

(Signed) Joseph Asprey M. D.
12/15 1916 (Address) Moscow Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 12/15 1916

20. UNDERTAKER: Glen Price — ADDRESS: moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. 224, South Howard St.)

File No. 16381
Registered No. 69
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bertha P. Bue.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: June (Month) 7 (Day) 1829 (Year)

7. AGE: 87 yrs. 5 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Peder Budden

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Karen Strander

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) MK. Bue
(Address) Enterprise, Ore.

15. Filed Dec 24 1916 D. J. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 8 1916, to Dec 21 1916, that I last saw h[illegible] alive on Dec. 21 1916, and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

La Grippe

(Duration) ..... yrs. ..... mos. 13 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Wyk M. D.
Dec 22 1916 (Address) Moscow Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 12/23 1916

20. UNDERTAKER: Glen Price | ADDRESS: Moscow

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61

Primary Registration District No. 1011

File No. 16382

Registered No. 75

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida Florence Roberts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1873 (Year)

7. AGE: 43 yrs. 9 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: Lafiaett Moody

11. BIRTHPLACE OF FATHER (State or Country): South Carolina

12. MAIDEN NAME OF MOTHER: Elizabeth Sparks

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Roberts
(Address) Juliaetta Ida.

15. Filed Dec 6 1916 J. F. Rae Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 28 1916., to Dec 5th 1916, that I last saw her alive on Dec. 4th 1916, and that death occurred on the date stated above, at 7 30 A. M.

The CAUSE OF DEATH* was as follows:
Septic Poisoning.

(Duration) yrs. mos. 12 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. T. Carothers M. D.
Dec 5th 1916. (Address) Moscow, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 7 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? Juliaetta Idaho.
Former or usual residence " "

19. PLACE OF BURIAL OR REMOVAL: Juliaetta Idaho | DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Glen Grice | ADDRESS: Moscow

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 124
Primary Registration District No. 2204
(No. ....., ... St.)

File No. 16384
Registered No. 24

1. PLACE OF DEATH.
County of Kootenai
City of Harrison

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Inez Grubb.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 2 (Day) 1913 (Year)

7. AGE: 1 Yrs. 7 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: C. F. Grubb

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Stella Ivey

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. F. Grubb
(Address) Harrison

15. Filed Jan 6 1917 — R. S. Jensen, Local Registrar

SYMS-YORK CO., PTRS. & STNRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1915, to Dec 12 1916, that I last saw her alive on Dec 1 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Carcinoma of liver.

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Dec 19 16 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison Cem — DATE OF BURIAL: 12/20 1916

20. UNDERTAKER: E. W. Ruby — ADDRESS: Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 16387
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orlando Fickland Calhoun

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: October (Month) 5 (Day) 1851 (Year)

7. AGE: 65 yrs. 2 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Georgetown, Wisc

10. NAME OF FATHER: Hugh Calhoun

11. BIRTHPLACE OF FATHER (State or Country): South Carolina ~~Wisconsin~~

12. MAIDEN NAME OF MOTHER: Anne Hull

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Vernon Calhoun
(Address) Buhl. Ida

15. Filed 12-15 1916 J. D. Mumbley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1916., to Dec 13 1916
that I last saw h~~im~~ alive on Dec 13 1916
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis
Arterio Sclerosis B.P. 190-275
for 2 mo before death.

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary): Pulmonary Edema

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. D. Mumbley M. D.
12/14 1916 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery
DATE OF BURIAL: 12/15 1916

20. UNDERTAKER: J E Schmidt
ADDRESS: Buhl, Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 39
Primary Registration District No. 2987
(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16388
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl

2. FULL NAME Conn Wm Skinner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov 13. 1907 (Month) (Day) (Year)

7. AGE: 9 Yrs. 1 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): St. Joseph. Mo.

10. NAME OF FATHER: Conn Skinner

11. BIRTHPLACE OF FATHER (State or Country): Superio Neb.

12. MAIDEN NAME OF MOTHER: Luella Parks

13. BIRTHPLACE OF MOTHER (State or Country): Clay Co. Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs C. E. Skinner
(Address) .....

15. Filed 12-15 1916. J. N. Newcomb Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 14 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1916, to Dec 12 1916, that I last saw her alive on Dec 12 1916, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Measles
..... (Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Pneumonia (Lobar)
..... (Duration) ..... yrs. ..... mos. 3 ds.
(Signed) A. T. McClusky M. D.
12/14/16 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl Ida — DATE OF BURIAL: Dec 17 1916

20. UNDERTAKER: H. B. Evans — ADDRESS: Buhl

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 16389
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Burke
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Marcia Elkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 10 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Burke Idaho

10. NAME OF FATHER M J Elkins

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Dora Brannon

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M J Elkins
(Address) .....

15. Filed 12-15 1916 J H Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1916, to Dec 15 1916, that I last saw her alive on Dec 14 1916, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Obstruction of Bowels

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J H Murphy M. D.
12-15 1916 (Address) Burke Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burke Ida. DATE OF BURIAL: 12/16 1916

20. UNDERTAKER: A B Evans ADDRESS: Burke Ida

SYMS - YORK CO., PTRS. & STNRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 16390
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Baby Bissonnette

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: December 16 1916 (Month) (Day) (Year)

7. AGE: ✓ yrs. ✓ mos. ✓ ds. IF LESS than 1 day how many ✓ hrs. or 30 min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Twin Falls Co, Idaho

10. NAME OF FATHER: Erman F. Bissonnette

11. BIRTHPLACE OF FATHER (State or Country): Floyd Co, Iowa

12. MAIDEN NAME OF MOTHER: Margaret L Mullen

13. BIRTHPLACE OF MOTHER (State or Country): Clay Co Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E F Bissonnette
(Address) Buhl Ida

15.
Filed 12-16 1916
J. T. Mumley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December, Dec, 16 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h ~~is alive on~~ ..... 191...
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Still born
Pressure during birth
Face presenting - Primipara
(Duration) Hardly nine yrs. mos. ds.

Contributory (Secondary): None
(Duration) yrs. mos. ds.

(Signed) A F Hutchinson M. D.
Dec 16 1916 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery
DATE OF BURIAL: 12/17 1916

20. UNDERTAKER: J E Schmidt
ADDRESS: Buhl Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 16391
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls.
City of Burl.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sylvia West

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. December 28 (Month) (Day) 1836 (Year)
7. AGE: Yrs. 79 Mos. 11 ds. 23
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Ohio.
10. NAME OF FATHER Asa Walker
11. BIRTHPLACE OF FATHER (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Mary Meeks
13. BIRTHPLACE OF MOTHER (State or Country) Ohio
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jessie McCutcheon
(Address) Buhl Idaho
15. Filed Dec 23 1916 J. N. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. 22 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 18 1916, to Dec. 21 1916, that I last saw h[illegible] alive on Dec. 21 1916, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. 0 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Chas. Witherbee M. D.
12-23 1916 (Address) Buhl

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl Ida. DATE OF BURIAL: Dec 24 1916
20. UNDERTAKER: A. B. Evans ADDRESS: Buhl

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 16392
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Paul Ray Shaub.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	Single

6. DATE OF BIRTH: Dec (Month) 27 (Day) 1916 (Year)

7. AGE: 0 yrs. 7 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Buhl Ida

10. NAME OF FATHER: E. J. Shaub.

11. BIRTHPLACE OF FATHER (State or Country): Emerson Iowa

12. MAIDEN NAME OF MOTHER: Eliza Bridgeman

13. BIRTHPLACE OF MOTHER (State or Country): London Eng.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Shaub
(Address)

15. Filed 12-27 1916 J. F. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Dec 27 1916, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Measles.
(Died suddenly.)

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) "Blue baby."
..... (Duration) since Birth. yrs. ..... mos. ..... ds.

(Signed) J. F. Murphy M. D.
12-27 1916 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl.	12-29 1916

20. UNDERTAKER	ADDRESS
E. J. Schmidt.	Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYNS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 16393
(No. ..... St.)
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Twin Falls.
City of Salmon Prairie.
If death occurs away from usual residence, give facts called for under special information. 6 mi South.

2. FULL NAME Priscilla Irene Fisher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): School girl

6. DATE OF BIRTH. July 7 (Month) (Day) 1909 (Year)

7. AGE: 7 Yrs. 5 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. School girl.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Okla.

10. NAME OF FATHER W. A. Fisher

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Leanna Cunningham

13. BIRTHPLACE OF MOTHER (State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. A. Fisher
(Address) Twin Falls

15. Filed 12-20 1916 John F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 17th (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1916, to Dec 17 1916, that I last saw h[illegible] alive on Dec 16 1916, and that death occured on the date stated above, at 9.40 A M.

The CAUSE OF DEATH* was as follows:
Valvular heart disease
.....
.....
(Duration) Yrs. 3 mos. — ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. Swerdlow M. D.
Dec 18 1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: Dec 20 1916

20. UNDERTAKER: Grossman & Evans ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 16394
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Rogerson
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Julia Antonitta Goldsworthy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb. (Month) × (Day) 1850 (Year)

7. AGE 66 Yrs. 10 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Chas. Sherman

11. BIRTHPLACE OF FATHER (State or Country): Conn.

12. MAIDEN NAME OF MOTHER: × Sealey

13. BIRTHPLACE OF MOTHER (State or Country): Conn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Horace Goldsworthy
(Address) Rogerson Idaho

15.
Filed 12-24 1916
John F. Loughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
12 (Month) — 22nd (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 1:00 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia
.....
.....
.....
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Tuberculosis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas J. Crosby, Coroner. ~~M. D.~~
19..... (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Twin Falls — DATE OF BURIAL: 12-24 1916

20. UNDERTAKER: Chas J. Crosby — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNE - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16395

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 37

Primary Registration District No. 1085

County of Twin Falls

City of " "

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Warner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Mar. 23 (Month) (Day) 1910 (Year)

7. AGE: 1 Yrs. 9 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Lawyer

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER L. A. Warner

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Ethel Mauker

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. A. Warner

(Address) Twin Falls

15. Filed 1-2- 1917 John E. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 31 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30th 1916, to Dec 31 1916, that I last saw her alive on Dec 31 1916 and that death occured on the date stated above, at 11.30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Jan 2 1917 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Jan 2 1917

20. UNDERTAKER: Goodman & Ames — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 16396
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of " "
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry H. McNeal

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Dec. (Month) 18 (Day) 1844 (Year)

7. AGE: 72 Yrs. — Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: McNeal

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Don't Know.

13. BIRTHPLACE OF MOTHER (State or Country): Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C E McNeal
(Address) Twin Falls

15. Filed 12-24-1916 John Houghlin Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30th 1916, to 12/22/ 1916, that I last saw him alive on 12/21/ 1916, and that death occured on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(Duration) Yrs. 6 mos. ..... ds.

Contributory (Secondary) Obstruction of bowels

(Duration ..... yrs. ..... mos. 5 ds.

(Signed) W. F. Pike M. D.

12/23/1916 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Dec. 24 1916

20. UNDERTAKER: Grannan & Eames — ADDRESS: Twin Falls

FORM V. S. No. 1-16 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of ... "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..., ... St.)

File No. 16398
Registered No. ...

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Wm Franklin McMahon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Aug 2nd (Month) (Day) 1856 (Year)

7. AGE
60 Yrs. 4 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Wm McMahon

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: x Long

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Cynthia McMahon
(Address) Rupert Idaho

15.
Filed Dec 17. 1916
John F. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 15 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1916, to Dec 15 1916
that I last saw him alive on Dec 14 11 AM 1916
and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Hypostatic Pneumonia
Arteria sclerosis

(Duration) ... Yrs. ... mos. 10 d.
Contributory (Secondary) Arteria sclerosis
(Duration 10 yrs. ... mos.
(Signed) Theodore E. Schwartz M.D.
19... (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin / Rupert — DATE OF BU... 19...

20. UNDERTAKER: A. J. Crosby — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24655

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 37

Primary Registration District No. 1082

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16399

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of Twin Falls,

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chelsie Cole

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant.

6. DATE OF BIRTH. Sept (Month) 29 (Day) 1915 (Year)

7. AGE: 1 Yrs. 2 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Infant.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Anadarco Okla.

10. NAME OF FATHER Wm Cole.

11. BIRTHPLACE OF FATHER (State or Country) Okla.

12. MAIDEN NAME OF MOTHER. Ella Tate.

13. BIRTHPLACE OF MOTHER (State or Country) Tennessee.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Cole

(Address) Twin

15. Filed 12. 10. 1916 John H Cowgill Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) — 9 (Day) — 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1916, to Dec 9 1916, that I last saw h. alive on Dec 8 1916, and that death occured on the date stated above, at 7 AM.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of Heart following Measles with out Eruption and Bronchopneumonia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Congenital Heart Disease Bronchopneumonia

(Duration ..... yrs. 1/4 mos. ..... ds.

(Signed) Duncan K Hartsock M. D.

12/9 1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: Dec 10th 1916

20. UNDERTAKER: Grossman and Ewer. — ADDRESS: Twin Falls.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 16400
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucy Dickerson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Dec. (Month) 24 (Day) 1867 (Year)

7. AGE: 67 Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Alabama

10. NAME OF FATHER: Geo. Offett

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: Sarah Connell

13. BIRTHPLACE OF MOTHER (State or Country): Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward Dickerson
(Address) Twin Falls Ida

15. Filed 12. 7- 1916 John S. Coughlin Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 5th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from about Aug 8th 1916, to Dec 1st 1916, that I last saw her alive on Sometime in Nov about 1916, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Cardiac failure

(Duration) 10 or 15 Yrs. mos. ds.
Contributory (Secondary) Exophthalmic Goitre
(Duration) 10 or 15 yrs. mos. ds.

(Signed) W. H. Pike M. D.
12/7/1916 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Dec. 7 1916

20. UNDERTAKER: Goodman & Evans — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. Weaver

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16402

Registered No. .....

1. PLACE OF DEATH

County of Twin Falls Registration District No. 87

City of " " (No. ..... St.) Primary Registration District No. 1085

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. M E. Scritchfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. October 21 1843
(Month) (Day) (Year)

7. AGE: 73 Yrs. 1 Mos. 10 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mo. or Ind. ?

10. NAME OF FATHER Unknown Foster

11. BIRTHPLACE OF FATHER (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M B. E Scritchfield

(Address) Twin Falls Ida

15. Filed 12-9 1916 John Houghlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12-3 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 25th 1916, to Dec 3d 1916, that I last saw h.r alive on about Nov 25th 1916, and that death occured on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Burned to death

(Duration) Mos. Yrs. mos. ds.

Contributory (Secondary) Had had Lagrippe some but it had nothing to do with death

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. W. Pike M. D.

12/9/1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls, DATE OF BURIAL: 12-5 1916

20. UNDERTAKER: C. J. Crosby ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Boyd.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16403

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Twin Falls

City of " " "

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. .... St.)

2. FULL NAME Mrs. Ethel Washington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug 4th (Month) (Day) 1886 (Year)

7. AGE 30 Yrs. 3 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Unknown Goodell

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Washington

(Address) Rogerson Ida

15. Filed 12-9- 1916

John H. Coughlin
Local Registrar

SYMS - YORK CO., PTGS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 — 2 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1916, to Dec 2 1916, that I last saw her alive on Dec 2 1916, and that death occured on the date stated above, at 1:15 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Dec 9 1916 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Twin Falls — DATE OF BURIAL: 12-4 1916

20. UNDERTAKER: Cloonby — ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16404

Registered No. 31

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

(No. ....., ... St.)

Registration District No. 19

Primary Registration District No. 2015

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Glordys Wayman.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 23 (Day) 1900 (Year)

7. AGE: 16 Yrs. 1 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ogden Utah.

10. NAME OF FATHER William Le. Wayman.

11. BIRTHPLACE OF FATHER (State or Country) Plain City Utah

12. MAIDEN NAME OF MOTHER Eliz. Walker.

13. BIRTHPLACE OF MOTHER (State or Country) West Weber.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. L. Wayman

(Address) Paul Ida.

15. Filed 12-16 1916

E. H. Rhuene. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 14. (Day) 1916. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 1916, to Dec. 14 1916, that I last saw h[er] alive on Dec. 12 1916, and that death occured on the date stated above, at 4:05 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

Some Time

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Uraemia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Schultz M.D. M. D.

12/15 1916. (Address) Rupert Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: 12-18 1916

20. UNDERTAKER: D. B. Galloghy — ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & STRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16405
Registered No. 32

1. PLACE OF DEATH.
County of Mendosa
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Clarence Williams
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 5 (Day) 1873 (Year)

7. AGE: 43 yrs. 4 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Robert Williams

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Mary [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth Williams
(Address)

15. Filed 1-10 1917 E. H. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 1916, to Dec. 7 1916, that I last saw him alive on Dec 7 1916, and that death occurred on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) yrs. mos. ds.
Contributory
(Secondary)
(Duration) 2 yrs. mos. ds.

(Signed) J. D. Lewis M. D.
12-8 1916 (Address) Eden

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chloe Cather | DATE OF BURIAL: ..... 191...

20. UNDERTAKER: W. O. Goodman | ADDRESS

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 18
Primary Registration District No. 2015
File No. 16406
Registered No. 33

1. PLACE OF DEATH.
County of Minidoka
City of Rupert
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pauper name given as Fenton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Unknown

6. DATE OF BIRTH.
Unknown (Month) (Day) 1 (Year)

7. AGE
about 56 yrs Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Unknown
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) "

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country) "

12. MAIDEN NAME OF MOTHER
"

13. BIRTHPLACE OF MOTHER
(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J.R. Hancock Emerton
(Address) Rupert Ida

15.
Filed 12-29 1916
E.H. Edmunds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1916, to Nov 30 1916, that I last saw h in alive on Nov 30 1916, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) 10 yrs. ..... mos. ..... ds.
(Signed) C.F. Coffey M. D.
12-30 1916 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOK. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 16409
Registered No. 36

1. PLACE OF DEATH.
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Abraham Redford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Sept 1 1847
(Month) (Day) (Year)

7. AGE
67 yrs. 3 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Robert Redford

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Lettice Ackersal

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. B. Redford
(Address) Rupert Idaho.

15.
Filed 1-10 1917 E. H. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec 7 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1- 1916, to Dec 9 1916, that I last saw h-- alive on Dec 7 1916, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF ~~DEATH~~* was as follows:
Pneumonia Lobar

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. H. Elmore M. D.
1-10 1917 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Heyburn Idaho	Dec 9 1916

20. UNDERTAKER	ADDRESS
W. A. Goodman	Rupert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DO NOT USE MARKING OR PERFORATED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Minidoka
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19
Primary Registration District No. 2015

File No. 16410
Registered No. 37
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Soren Larson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: May (Month) 18 (Day) 1845 (Year)

7. AGE: 71 yrs. 7 mos. 5 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Lars Larson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lars Larson
(Address) Rupert

15.
Filed 1 — 10 1917 E. H. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1916, to Dec 11 1916
that I last saw h~~e~~ alive on Dec 11 1916
and that death occurred on the date stated above, at 24 M.

The CAUSE OF DEATH* was as follows:
Pneumonia Broncho

(Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Kennaff M. D.
Jan 9 1917 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Cemetery	Dec 14 1916
20. UNDERTAKER	ADDRESS
W. G. Gardner	Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2013
File No. 16411
Registered No. 38

1. PLACE OF DEATH.
County of Bonneville
City of Heyburn (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Olive A. Boyd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Oct (Month) 30 (Day) 1874 (Year)

7. AGE: 40 yrs. 0 mos. 10 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Chas Conrad

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Conrad

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William B Boyd
(Address) .....

15.
Filed 1 — 10 1917 E. H. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 9 (Day) 1915 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 9 1915, to Dec. 9 1916, that I last saw her alive on Nov. 8 1915, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Mitral incompetency

(Duration) ? yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Kennagy M. D.
19.... (Address) Rupert Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Heyburn Cemetery | DATE OF BURIAL: Nov 11 1915

20. UNDERTAKER: W. A. Gardner | ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16412
Registered No. 39

1. PLACE OF DEATH.
County of Minidoka
City of Eden (No. ....., ... St.)

Registration District No. 19
Primary Registration District No. 2015

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Packer Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Don't Know (Month) (Day) (Year)

7. AGE: about 65 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nova Scotia

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adelia Smith
(Address) Eden Idaho

15.
Filed 1-10 1917
E. H. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 16 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1916, to Nov 15 1916 that I last saw h[illegible] alive on Nov 15 1916 and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Peritonitis General
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Heart
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Gleason M. D.
Nov 16 1916 (Address) Hazelton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: —
DATE OF BURIAL ..... 191...

20. UNDERTAKER: —
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 120

County of Cassia Primary Registration District No. 2199

City of Burley Hill (No. ..... St.)

File No. 16413

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Leon Harvey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): marr

6. DATE OF BIRTH: Oct (Month) 9 (Day) 1848 (Year)

7. AGE: 68 yrs. 1 mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel Poulton
(Address) Oakley Idaho

15.
Filed 1-6 1916 Florence Dahlquist. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 1916, to Dec 14 1916, that I last saw h[illegible] alive on Dec 14 1916, and that death occurred on the date stated above, at 4-9 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 25 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. E. Wilson M. D.

14 1916 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Marion Idaho — DATE OF BURIAL: Dec 17 1916

20. UNDERTAKER: Samuel Poulton — ADDRESS: Oakley Idaho

ARMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 120
Primary Registration District No. 2199
File No. 16414
Registered No.

1. PLACE OF DEATH.
County of Cassia
City of Basin
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Garvin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Babe

6. DATE OF BIRTH. Dec (Month) 7 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds. 3 hrs. 30 min.
IF LESS than 1 day how many

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Raymond Garvin

11. BIRTHPLACE OF FATHER (State or Country) Lincoln Utah

12. MAIDEN NAME OF MOTHER Mamie Fairchild

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Raymond Garvin
(Address) Basin Idaho

15.
Filed 12-30 1916 Florence Dahlquist Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1916, to Dec 7 1916, that I last saw him alive on Dec 7th 1916, and that death occured on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:
Congenital Dyspnoea
(Duration) Yrs. 3½ hrs. mos. ds.
Contributory (Secondary) Premature birth
(Duration) yrs. mos. ds.
(Signed) J. E. Baugenwalter M. D.
12/7 1916 (Address) Oakley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Basin Idaho — DATE OF BURIAL: Dec. 8 1916

20. UNDERTAKER: Adams & Sogers — ADDRESS: Oakley, Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 120

Primary Registration District No. 2199

File No. 16415

County of Cassia Idaho

City of Oakley (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert neal Buchanan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct Saturday 28 (Month) (Day) 1915 (Year)

7. AGE: 1 yrs. 1 mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Twin falls Idaho

10. NAME OF FATHER Birgan g Buchanan

11. BIRTHPLACE OF FATHER (State or Country) mitchell. Co. N C

12. MAIDEN NAME OF MOTHER Jennie neal

13. BIRTHPLACE OF MOTHER (State or Country) Neb Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Birgan g Buchanan
(Address) Stanley Idaho

15.
Filed 12-12 1916 Florence Reed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29 1916, to Dec 1 1916, that I last saw him alive on Dec 1916, and that death occurred on the date stated above, at 6P M.

The CAUSE OF DEATH* was as follows:

Bowels Inflamation

(Duration) — yrs. — mos. 16 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hughes M. D.

19.... (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. 8 days. In the State 1 yrs. 1 mos. 8 days.

Where was disease contracted if not at place of death? Stanley Idaho

Former or usual residence Stanley Idaho

19. PLACE OF BURIAL OR REMOVAL: B F Wilson — DATE OF BURIAL: Dec 3 1916

20. UNDERTAKER: B F Wilson — ADDRESS: Oakley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16416

Registered No. .....

Registration District No. 120

Primary Registration District No. 2199

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Cassia

City of Basin

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vanetta Bingham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Baby

6. DATE OF BIRTH. Sept (Month) 6 (Day) 1916 (Year)

7. AGE ..... Yrs. 3 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sunnydale Idaho

10. NAME OF FATHER Charles C Bingham

11. BIRTHPLACE OF FATHER (State or Country) Teton Basin Idaho

12. MAIDEN NAME OF MOTHER Lillie May Kidd

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles C Bingham

(Address) Basin Idaho

15.

Filed 12-19 1916 Florence Dahlquist Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1916, to Dec 10 1916, that I last saw her alive on Dec 9 1916, and that death occured on the date stated above, at 1201 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Baumgartner M. D.

19.... (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Basin Idaho — DATE OF BURIAL: Dec. 11 1916

20. UNDERTAKER: J S McIntosh — ADDRESS: Basin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & STNRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 120

County of Cassia

Primary Registration District No. 2199

File No. 16417

City of Oakley (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Andrew Critchfield

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 8 (Day) 1865 (Year)

7. AGE: 50 yrs. 7 mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm A.

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Orissa M Bates

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lewis Critchfield
(Address) Oakley Idaho Jr. R

15. Filed 12-20 1916 Florence Dahlquist Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1916, to Nov 30 1916, that I last saw h[er] alive on Nov 30 1916, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 15 ds.

Contributory (Secondary) Myocarditis Endocarditis

(Duration) don't know yrs. ..... mos. ..... ds.

(Signed) C. P. O'Shea M. D.

19 .... (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Oakley — DATE OF BURIAL: Dec 1 1916

20. UNDERTAKER: B. F. Wilson — ADDRESS: Oakley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 120
Primary Registration District No. 2199
File No. 16418
Registered No. .....

1. PLACE OF DEATH.
County of Cassia
City of Oakley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information. Marion.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emanuel Berg.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. Aug. (Month) 5 (Day) 1823 (Year)
7. AGE: 93 Yrs. 5 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Sweden
10. NAME OF FATHER: Matthew Berg.
11. BIRTHPLACE OF FATHER (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Don't Know.
13. BIRTHPLACE OF MOTHER (State or Country): Sweden
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emel Berg
(Address) Marion
15.
Filed 12-30 1916 Florence Dahlquist Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 25 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 12-9 M.
The CAUSE OF DEATH* was as follows:
No Dr in attendance
From all information
can get he died a natural
death (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) Florence Dahlquist M.D.
Dec 27 1916 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Marion — DATE OF BURIAL: 12-27 1916
20. UNDERTAKER: Hanly Sessions — ADDRESS: Marion

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STMS - YORK CO., PTRS. A SORS. 24654

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16419
Registered No.

1. PLACE OF DEATH.
County of Cassia
City of Oakley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 120
Primary Registration District No. 199
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Chas. A. Dunmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Dec. (Month) 27 (Day) 1872 (Year)

7. AGE: 44 yrs. 0 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm Dunmer

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah Hyde

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Dunmer Jr.
(Address) Oakley Idaho

15.
Filed 12-30 1916 Florence Dahlquist Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 20 M.

The CAUSE OF DEATH* was as follows:
Did not have a doctor
probable cause of death
Endocarditis Myocarditis
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
Dec 27 1916 (Address) ..... [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley Cemetery
DATE OF BURIAL: Dec 28 1916

20. UNDERTAKER: [illegible]
ADDRESS: Oakley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

City of Vallonia (No. ....., ... St.) Registered No. 1 (1917)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby 7th son Son Leslie & Ester Whitson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 27th (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many. 8 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Vallonia Ida

10. NAME OF FATHER Leslie L. Whitson

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Ester May Elliott

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leslie Whitson

(Address) Vallonia Ida

15. Filed 1/8 1917 J. E. Lewellyn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 28th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1916, 6 PM to Dec 27 1916, 7:30 PM that I last saw him alive on Dec 27 7 a.m. 1916, and that death occured on the date stated above, at 2 A. M. Dec 28-1916

The CAUSE OF DEATH* was as follows: Premature Birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature Birth

(Duration ..... yrs ..... mos ..... ds.

(Signed) John Lang Hix M. D.

19..... (Address) Vallonia Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL At Ranch — DATE OF BURIAL Dec 29 1916

20. UNDERTAKER — ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 24658

Vollmer, Ida. Jan. 6" 1917.

Dr. R. E. Dunlap

Ilo, Ida.,

Dear Doctor:-

These papers are late getting into your hands and are also somewhat irregular but I did not know of this Baby's death until after its burial, As frequently happens in such cases was expcting it however and think it O.K. Do not know how particular people should be to get their permits and follow the regular routine as in the case of Adults or older children.

These certificates as you see were at first sent to Dr. Rogers.,

Yours Respectfully,

J. C. McLaughlin

Recd 1/8 - 16

R E Dunlap

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16421

Registered No.

1. PLACE OF DEATH.

County of Custer

City of Challis

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Michael Kelley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M	Wh.	Single

6. DATE OF BIRTH

Not known (Month) 1 (Day) (Year)

7. AGE

82 yrs. mos. ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work ... Stationary engineer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE

(State or Country) Not known

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country) Not known

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. E. Kistler

(Address) Challis, Ida

15.

Filed 191 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 10th. 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 1916., to Nov. 10th 1916,

that I last saw him alive on Nov. 9th 1916,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) Not known mos. ds.

(Signed) C. E. Kistler M. D.

19 (Address) Challis Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence On county eight years

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Challis	Nov. 12 1916
20. UNDERTAKER	**ADDRESS**
K. D. Williams	Challis, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be given in YEARS. Exact statements are required. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 3168
File No. 16422
Registered No. 7

1. PLACE OF DEATH.
County of Shoshone
City of Orofino.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm. H. Stevens

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1850 (Year)

7. AGE: 66 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Locomotive Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): S. Carolina

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Stevens
(Address) Orofino. Idaho

15. Filed Feby 1 1917
Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 27 1916, to Dec. 25 1916, that I last saw him alive on Dec 25 1916, and that death occured on the date stated above, at 3.30 P M.

The CAUSE OF DEATH* was as follows:
Arterio - Sclerosis

(Duration) 9 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
(Duration ..... yrs. 3 mos. ..... ds.

(Signed) John Stevens M. D.
Dec 25 1916 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 2 mos. 28 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Bonner Co. Idaho
Former or usual residence Idaho

19. PLACE OF BURIAL OR REMOVAL: Sanitarium Cemetery — DATE OF BURIAL: Dec 27 1916

20. UNDERTAKER: Peter M. Johnson — ADDRESS: Orofino

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 16423
Registered No. 1

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Woodruff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) ..... (Day) ..... 1856. (Year)

7. AGE: 60 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Newyork

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Johnwilsmens
(Address) Orofino, Idaho

15. Filed Feby 1 1917
J. M. Favel
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19. 1916, to Dec 23. 1916, that I last saw him alive on Dec 23 1916, and that death occured on the date stated above, at 10.30 P M.

The CAUSE OF DEATH* was as follows:
Erysipelas

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Insanity.
(Duration) ..... yrs. 1 mos. 10 ds.

(Signed) Johnwilsmens M. D.
Dec 24 1916 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs. 1 mos. 4 days
Where was disease contracted if not at place of death? Lewiston. for insanity Orofino .. Erysipelas
Former or usual residence Lewiston Idaho

19. PLACE OF BURIAL OR REMOVAL: Sanitarium Cemetery
DATE OF BURIAL: Dec 26 1916

20. UNDERTAKER: Peter M. Johnson
ADDRESS: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
(No. ..... St.)

File No. 16424
Registered No. 141

1. PLACE OF DEATH.

County of .....
City of Mink Creek

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carl C. Christensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Aug (Day) 24 (Year) 1843

7. AGE: 67 Yrs. 11 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark. Island.

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TREE TO THE BEST OF MY KNOWLEDGE.
(Informant) Adam Keller
(Address) Mink Creek

15.
Filed ..... 191..... Dan Cantu
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 27 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from No doctor in Attendance 191..., to ..... 191...,
that I last saw h— alive on — 191...,
and that death occured on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Dropsical Death while at work — was Carried Forward.
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) .....
(Duration — yrs. — mos. — ds.
(Signed) Allen R Curtis (Grave Pct) M. D.
19..... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mink Creek — DATE OF BURIAL: Aug 27 1914

20. UNDERTAKER: None — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16426

Registered No. 53

1. PLACE OF DEATH.

County of Franklin

City of Preston

(No. ....., ... St.)

Registration District No. 27

Primary Registration District No. 2119

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Abraham M Treyster

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 14 (Day) 1842 (Year)

7. AGE: 74 Yrs. 6 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wholesale dealer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Abraham Treyster

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER: Sarah

13. BIRTHPLACE OF MOTHER (State or Country): U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elsie Kopcal
(Address) Preston Idaho

15.
Filed Aug 10 1916 Dake Curtis
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1916, to Aug 9 1916, that I last saw h[illegible] alive on Aug 2 1916, and that death occured on the date stated above, at 10:40 A.M.

The CAUSE OF DEATH* was as follows:
Asthma, Rheumatism and a failing heart.

(Duration) 6 Yrs. mos. ds.

Contributory (Secondary) Asthma

(Duration 28 yrs. mos. ds.

(Signed) Allen R Curtis M. D.

Aug 10 1916 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible]
DATE OF BURIAL: Aug 11 1916

20. UNDERTAKER: Grow
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-1

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. [redacted] District No. 27

County of ~~Oneida~~ Franklin Primary Registration District No. 2119

File No. 16427

City of Clifton Ida. (No. ....., ... St.)

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Henderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug. (Month) 9 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds. 4 hrs.

IF LESS than 1 day how many 4 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Clifton Idaho

10. NAME OF FATHER: Adelbert H Henderson

11. BIRTHPLACE OF FATHER (State or Country): Wyoming

12. MAIDEN NAME OF MOTHER: Sarah Alice Vanhuben

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mariam Henderson

(Address) Clifton

15.

Filed Aug. 16 1917 D. A. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 9-16 1916, to 8/9 1916, that I last saw h.s. alive on Aug 9 1916, and that death occured on the date stated above, at 11 a.m. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) — Yrs. — mos. Ind Hours ds.

Contributory (Secondary) .....

(Duration — yrs. — mos. — ds.

(Signed) A. L. Cutler M. D.

19.... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clifton — DATE OF BURIAL: 8/11 1916

20. UNDERTAKER: None — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16428
Registered No.

1. PLACE OF DEATH.
County of Teton
City of Leidore (No. ....., ... St.)

Registration District No. 42
Primary Registration District No. 2153

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy Lipe

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: June (Month) Twenty (Day) 1832 (Year)

7. AGE: 84 yrs. 7 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Geo Yeaman

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Elizabeth Lot

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos Denny
(Address) Leadore Idaho

15.
Filed Jan 18 1917 Mrs M. J. Pollock
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
..... 191...
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27, 1916 to Nov 29, 1916
that I last saw h[illegible] alive on Nov. 29 1916
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Brights disease, with cardiac complications

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B H Brown M. D.
Dec 30 1916 (Address) Gilmore, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of .....

(No. ....., ... St.)

Registration District No. 5

Primary Registration District No. 2009

File No. 16429

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Constable

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	Married

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1 (Year)

7. AGE about 66 yrs ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Jackson

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Whitcatt

(Address) Falks Idaho

15.

Filed ..... 191.... ..... Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

..... (Month) ..... (Day) 191.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from for several months 191.... to ..... 191...., that I last saw h.. alive on 17 December 1916, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(Duration) several Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm T Drysdale M. D.

19.... (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Falks Idaho — DATE OF BURIAL Jan 3 1916

20. UNDERTAKER C A Buckmum — ADDRESS Emmett Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2057

File No. 16430

Registered No. 1

1. PLACE OF DEATH.

County of Ada

City of ~~Hot~~ Boise

(No. 4 Miles East of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Sutton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 14 (Day) 1847 (Year)

7. AGE: 69 Yrs. 7 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Princeton N.J.

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER: Dont Know (State or Country)

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER: Dont Know (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. F. M. Blair

(Address) 1504 N 25 Boise

15. Filed Jan 1st 1917 E. A. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1916, to Dec 30 1916, that I last saw him alive on Oct 1916, and that death occured on the date stated above, at 1. P.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. H. Tallman M. D.

1/4 1917 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Ada County, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery DATE OF BURIAL: 1/1 1917

20. UNDERTAKER: Schreiber & Sidenfaden ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16431

1. PLACE OF DEATH

County of Twin Falls

City of .....

Registration District No. 37

Primary Registration District No. 1042

(No. .... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry Shelly

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan (Month) 27 (Day) 1908 (Year)

7. AGE: 8 Yrs. 10 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School-boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Eugene Shelly

11. BIRTHPLACE OF FATHER (State or Country) Neb

12. MAIDEN NAME OF MOTHER Emma Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Eugene Shelly

15.

Filed 12-28 1916

John F. Laughlin
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12. Jan 26 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-20 191..., to 12-26 1916., that I last saw h.. alive on 12-25 1916., and that death occured on the date stated above, at 9 10/60 M.

The CAUSE OF DEATH* was as follows:

Streptococcus
Meningitis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Measles

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John F. Laughlin M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls. DATE OF BURIAL: 12-28 1916

20. UNDERTAKER: C J Crosby ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2016
(No. ....., ... St.)

File No. 16432
Registered No. 16

1. PLACE OF DEATH.
County of Lincoln
City of Dietrich
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah ann Hasting

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. April 26 1852
(Month) (Day) (Year)

7. AGE 63 yrs 6 months ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Indiana U. S.

10. NAME OF FATHER Unknown
Surname Baton

11. BIRTHPLACE OF FATHER
(State or Country) Iowa U S

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. W. Hasting
(Address) .....

15. Dec 23 1916 J L Turner
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 22 1916 to Dec. 22 1916, that I last saw h[illegible] alive on Dec. 22 1916, and that death occured on the date stated above, at 1.45 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Cardiac Failure
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. L. Tellen M. D.
19..... (Address) Shoshone, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or, usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. John Wash — DATE OF BURIAL: .....191.....

20. UNDERTAKER: O J Brennan — ADDRESS: Shoshone

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16433
Registered No.

1. PLACE OF DEATH.
Registration District No. 38
Primary Registration District No. 2138
County of Blaine
City of Hansfield (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Carrie Muffley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 58 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Osage Iowa

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Hansfield Idaho

15. Filed Aug 4 1916 D O Higgs M D Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1916, to Aug 3 1916, that I last saw her alive on Aug 3 1916, and that death occurred on the date stated above, at 6 30 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Breast
Toxemia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D O Higgs M. D.
Aug 4 1916 (Address) Hansfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted.
If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Osage Iowa
DATE OF BURIAL ..... 191...

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 v 5
File No. 16436
Registered No. 2

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Otha Lucile Gneiting

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH. May (Month) 11 (Day) 1911 (Year)

7. AGE 5 Yrs. 7 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Abraham Gneiting

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Anna Oswald

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anna Gneiting
(Address) Idaho Falls Idaho

15. Filed 1/9 191 7 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 20 (Day) 191 4. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1914, to Dec 20 1914, that I last saw her alive on Dec 20 1914, and that death occured on the date stated above, at ..... M.

THE CAUSE OF DEATH* was as follows:

Stricture of oesophagus

(Duration) ..... Yrs. 3 mos. ..... ds.
Contributory (Secondary) Pertonitis
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) [signature] M. D.
Jan 9 1917 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Grant Idaho — DATE OF BURIAL Jan 11 1917

20. UNDERTAKER [signature] — ADDRESS [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of St Charles
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5-5
Primary Registration District No.
(No. ..., ... St.)

File No. 16437
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lenard Floyd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Males	White	Widowed

6. DATE OF BIRTH
June (Month) 17 (Day) 1837 (Year)

7. AGE
78 yrs. 11 mos. [illegible] ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Byfield. Mass.

10. NAME OF FATHER Enoch Floyd

11. BIRTHPLACE OF FATHER (State or Country) Same

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. J. Floyd
(Address) Bloomington Ida

15.
Filed Feb 13 191? John Mattson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 5 (Day) 191[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at ...M.
The CAUSE OF DE[illegible]* was as follows:

.....
.....
.....
..... (Duration) ... yrs. ... mos. ... ds.
Contributory
(Secondary)
..... (Duration) ... yrs. ... mos. ... ds.
(Signed) ..... (..... M. D.
..... 19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ... 191...

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 16438
Registered No. ____

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
(No. ____ ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edwin Geer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH. Aug (Month) 18 (Day) 1845 (Year)
7. AGE 68 Yrs. ____ Mos. ____ ds. IF LESS than 1 day how many ____ hrs. or ____ min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): ____
9. BIRTHPLACE (State or Country): Michigan England
10. NAME OF FATHER: Don't Known
11. BIRTHPLACE OF FATHER (State or Country): " "
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Nina Geer
(Address) Montpelier
15. Filed Nov 17 1916 H H Kling Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 16 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1916, to Nov 16 1916, that I last saw him alive on Nov. 16 1916, and that death occured on the date stated above, at 6.50 a M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ____ Yrs. ____ mos. 12 ds.
Contributory (Secondary) Senile Dementia
(Duration ____ yrs. ____ mos. ____ ds.
(Signed) J.H. Lyon M. D.
Nov 16 1916 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. 6 days
Where was disease contracted if not at place of death? Bennington Ida
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Bennington Ida. DATE OF BURIAL: Nov 18 1916
20. UNDERTAKER: J.M. Williams ADDRESS: Montpelier

Vincent Thrn. Co.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16439
Registered No. .....

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Washington
City of Emmett

2. FULL NAME Fred. J. Cornett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Feby (Month) 1 (Day) 1914 (Year)

7. AGE
1 Yrs. 8 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE
(State or Country) Idaho. Washington Co.

10. NAME OF FATHER
Isaac N. Cornett

11. BIRTHPLACE OF FATHER
(State or Country) Benton County Oregon

12. MAIDEN NAME OF MOTHER
Ellis Jones.

13. BIRTHPLACE OF MOTHER
(State or Country) Washington Co. Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Isaac N Cornett
(Address) .....

15.
Filed Oct 16 1916
Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
10 (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-4 1916, to 10-4 1916, that I last saw him alive on 10-4-1916, and that death occured on the date stated above, at 9 0 M.

The CAUSE OF DEATH* was as follows:
Obstruction of bowels with malignant tumor

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Fadchmuz M. D.
19..... (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16440

Registered No.

1. PLACE OF DEATH. Registration District No.

County of Bear Lake Primary Registration District No.

City of Paris (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Nye

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 21 (Day) 1840 (Year)

7. AGE: 76 yrs. 7 mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hammersel Shire England

10. NAME OF FATHER: John Nye

11. BIRTHPLACE OF FATHER (State or Country): Dont Know England

12. MAIDEN NAME OF MOTHER: Charlotte Hasma

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo F Bunn
(Address) Paris Ida

15.
Filed ..... 191...
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 6 1916 to Dec. 11 1916
that I last saw h[illegible]alive on Dec. 11 1916
and that death occurred on the date stated above, at 2 10 P.M.
The CAUSE OF DEATH* was as follows:
Hemiplegia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Easton M. D.
Dec 12 1916 (Address) Paris Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris Ida — DATE OF BURIAL: Dec 14 1916

20. UNDERTAKER: Geo Bunn — ADDRESS: Paris

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16441

Registered No. 48

1. PLACE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston, Ida. (No. Poor Farm St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Hammond

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: 12 (Month) / 5 (Day) / 1916 (Year)

7. AGE: 85 yrs. 8 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Miner.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Connaseaca

10. NAME OF FATHER: Edward Hammond

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Boffo

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. J. Hamb
(Address) Lewiston

15. Filed 1-10-1917 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) / 5 (Day) / 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/1 1916, to 12/5 1916, that I last saw h[illegible] alive on 11/30 1916, and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Sailing Compensation

(Duration) 5 yrs. mos. ds.

Contributory (Secondary) Senility & Cerebral Embolism

(Duration) 7 yrs. mos. ds.

(Signed) F. J. Hamb M. D.

12/5/1916 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was Disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 12/5 1916

20. UNDERTAKER: [illegible] — ADDRESS: Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 16442
Registered No. 9

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josiah Burnside

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Jan 23 1858
(Month) (Day) (Year)

7. AGE: 58 Yrs. 11 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Robert Burnside

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Nancy Austin

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mrs Eugene Gahler
(Address):

15.
Filed ..... 191..
Local Registrar

SYMS - YORK &b., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 31st 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/28 1916, to 12/31 1916, that I last saw him alive on 12/31 1916, and that death occured on the date stated above, at 3.4 P.M.

The CAUSE OF DEATH* was as follows:
Dyphoid.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Chas V. Greenaway M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos. 2 days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence: Ada County, Ida.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: 1/2 1917

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

Grimm

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 3-25 M. 1-16-13.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Registration District No. 7
Primary Registration District No. 16444

1. PLACE OF DEATH.
County of Franklin
City of Franklin (No. ..... St.) Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maragret Whitehead

If death occurred in a hospital, institution, or camp give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Oct (Month) 17 (Day) 1844 (Year)

7. AGE: 72 Yrs. 1 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER John Green

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Green

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John W Whitehead
(Address) Franklin Ida.

15.
Filed Dec 7 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 4 (Day)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1916, to Dec 4
that I last saw her alive on Dec 4
and that death occured on the date stated above, at
The CAUSE OF DEATH* was as follows:
a Influenza
(Duration) ..... Yrs. ..... mos.
Contributory (Secondary) Nephritis, Mayo
(Duration) ..... yrs. ..... mos.
(Signed) T. W. Lucas
Jan 5 1917 (Address) Weston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE 12/8

20. UNDERTAKER S Kindmore | ADDRESS Pre

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16445

1. PLACE OF DEATH.

County of Canyon
City of Payette
(No. ..... St.)

Registration District No. 4
Primary Registration District No. [illegible]

Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Audrie Marguerite Woodward

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. (Month) 20 (Day) 1913 (Year)

7. AGE: 3 Yrs. 2 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canyon Co. Idaho

10. NAME OF FATHER: Jesse Charles Woodward

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Elizabeth M Morgan

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J R Woodward
(Address) Payette Ida

15. Filed Dec 17 1916 J R Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1916, to Dec 16 1916, that I last saw h[illegible] alive on Dec 12 1916, and that death occured on the date stated above, at [illegible] P. M.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J R Woodward M. D.
12/17 1916 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Sparta, Wis. DATE OF BURIAL: 12/23 1916

20. UNDERTAKER: E C Landrum ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 16446
Registered No. 41

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon
City of Payette

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob Alonzo Kinsey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 11 (Day) 1856 (Year)

7. AGE: 60 Yrs. 3 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: Daniel Kinsey

11. BIRTHPLACE OF FATHER (State or Country): O

12. MAIDEN NAME OF MOTHER: Rachel Stevens

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H H Kinsey
(Address) Fruitvale Idaho

15.
Filed Dec 11 1916
J R Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1916, to Dec 9 1916, that I last saw h[illegible] alive on Dec 9 1916, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J R Woodward M. D.
12/12/1916 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Ida
DATE OF BURIAL: Dec 12 1916

20. UNDERTAKER: Glenn C Landon
ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16447
Registered No. 94

1. PLACE OF DEATH.
County of Canyon
City of Middleton
(No. ....., ... St.)
Registration District No. 3
Primary Registration District No. 2005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Milo G. Wallihan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 9 (Day) 1916 (Year)

7. AGE: Yrs. 6 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Jim G. Wallihan

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Theresa Daly

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) ..... Jas G Wallihan
(Address) Middleton Idaho

15. Filed 12-13- 1916 John S. Freyer Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3rd 1916, to Dec 11 1916, that I last saw h. 1m alive on Dec 11 1916, and that death occured on the date stated above, at 12-1½a M.

The CAUSE OF DEATH* was as follows:
Whooping Cough —
+ Pneumonia

(Duration) ..... Yrs. 2 mos. — ds.
Contributory (Secondary) Whooping Cough
(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) J. S. Freyer M. D.
12-13 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Middleton — DATE OF BURIAL: 12-13- 1916

20. UNDERTAKER: Beckham Cas Co — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1003

(No. .... St.)

File No. 16448

Registered No. 93

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Josephine Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. May (Month) 30 (Day) 1839 (Year)

7. AGE: 77 Yrs. 6 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House keeping

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indianna

10. NAME OF FATHER: Peter Roberts

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Sarah Bibby

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. E. Smith

(Address) Caldwell Idaho

15.

Filed 12-13-1916 John D. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9- 1916, to Dec 12 1916, that I last saw her alive on Dec 11 1916, and that death occured on the date stated above, at 1-30 A M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Bronchial Asthma

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Foley M. D.

12/13/1916. (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: Dec 13 1916

20. UNDERTAKER: Pethham Case Co ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 16450
Registered No. 97

1. PLACE OF DEATH.
County of Canyon
City of Caldwell Idaho
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Gertrude Myers

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Dec (Month) 4 (Day) 1876 (Year)

7. AGE
40 Yrs. — Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER P. H. Engel

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Mary Brosner

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Maurice H. Myers
(Address) Caldwell Idaho

15.
Filed Dec. 21 1916
John S. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. A. Harris Canyon Co. ~~M. D.~~
12/21/1916. (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Canby Oregon
DATE OF BURIAL: 12/24/1916

20. UNDERTAKER: Benford Ferry Co.
ADDRESS: Caldwell Idaho

SYMS - YORK CO., PTRS. & SOBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

(No. ....., ... St.)

File No. 16451

Registered No. 98

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur W. Porter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 25 (Day) 1862 (Year)

7. AGE: 54 Yrs. 11 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Druggist
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Samuel Porter

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Virginia Christman

13. BIRTHPLACE OF MOTHER (State or Country): Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Porter
(Address) Caldwell

15. Filed 12-26-1916 John S. Meyers Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 8 1916, to Nov 25 1916, that I last saw h[illegible] alive on Nov 25 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
General Paresis

(Duration) Yrs. 2 mos. 0 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
12/26 1916 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 12-27-1916

20. UNDERTAKER: A A Faris — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 16452
Registered No. 99

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thos. Harvey McCullough
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH. Dec (Month) 7 (Day) 1845 (Year)

7. AGE: 71 Yrs. — Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Samuel McCullough

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Querry

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thos H McCullough
(Address) Caldwell Idaho

15. Filed 12-27-1916 John S. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1916, to Dec 27 1916, that I last saw him alive on Dec 27 1916 and that death occured on the date stated above, at 4 A. M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) Yrs. mos. 6 ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) S. J. Mull M. D.
12-27 1916 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Medaryville Indiana — DATE OF BURIAL 191

20. UNDERTAKER: Beckham Case Co — ADDRESS: Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 16453
Registered No. 100

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julia Alice Berry.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb (Month) 11 (Day) 1916 (Year)

7. AGE ..... Yrs. 10 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. —
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE (State or Country) Idaho, Boise

10. NAME OF FATHER J. A. Berry.

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Lillie Alice Ayers

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. G. Berry
(Address) Caldwell Idaho.

15. Filed 12-29- 1916. John P. Meyer. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1916., to Dec 28 1916., that I last saw her alive on Dec 27 1916., and that death occured on the date stated above, at 1-A. M.

The CAUSE OF DEATH* was as follows:

Capilliary Bronchitis

(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Nephritis & Spinal Infection

(Duration ..... yrs. ..... mos. 4 ds.

(Signed) C. M. Kelly M. D.
12-29 1916 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: Dec 29 1916

20. UNDERTAKER: Peckham Bros. ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16454

Registered No. 101

1. PLACE OF DEATH.

County of Canyon

City of Middleton

(No. ....., ... St.)

Registration District No. 3

Primary Registration District No. 2005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Berry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. Mar (Month) 28 (Day) 1841 (Year)

7. AGE: 75 Yrs. 9 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indianna

10. NAME OF FATHER: Wm. Robinson

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. E. Murphy
(Address) Middleton Idaho

15.
Filed Dec. 29th 1916 John D. Meyer Local Registrar

SYMS - YORK CO., PTRS. & RBRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1916 to Dec 29 1916, that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 5-30 A.M.

The CAUSE OF DEATH* was as follows:
Apoplexy, Apoplexy

(Duration) ..... Yrs. Suddden mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

12/29 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Provo Utah — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Peckham Case Co — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12 32
Primary Registration District No. 2-1 C
(No. ..... , ... St.)

File No. 16456
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm. Bennett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
— (Month) — (Day) 1863 (Year)

7. AGE
53 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York
10. NAME OF FATHER: Michael Bennett
11. BIRTHPLACE OF FATHER (State or Country): New York
12. MAIDEN NAME OF MOTHER: Shaughnessy
13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. R. Bennett
(Address) 1482-27 Seattle Wash

15.
Filed 12/30 191 — Geo. S. Loshe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Oct (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 191 , to Oct 23 1916, that I last saw h im alive on Oct 22 1916, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Fracture of skull (vault & also base)
about 9 hours
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. S. Kennett M. D.
Oct 26 1916 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho | DATE OF BURIAL: Oct 25, 1916

20. UNDERTAKER: M. C. Thornhill | ADDRESS: Kellogg, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62
Primary Registration District No. 2172
File No. 16457
Registered No. 2

1. PLACE OF DEATH.
County of Latah
City of Genesee (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa Carbuhn.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: October 10th. (Month) (Day) 1859 (Year)

7. AGE: 57 yrs. 1 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers Wife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Christian Scharnhorst.

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Frederika Neubauer.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dedrick Scharnhorst.
(Address) Genesee, Idaho.

15. Filed 12-9 1916 W. H. Thain Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1916, to Dec 6 1916
that I last saw h..... alive on ..... 191....
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Patient was dead when
I reached her
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Thorn M. D.
Dec 8 1916 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: J. E. Lauer — DATE OF BURIAL: 12-10 1916

20. UNDERTAKER: J. E. Lambert — ADDRESS: Genesee Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16458

Registered No. 32

1. PLACE OF DEATH.

Registration District No. 21

Primary Registration District No. 2022

County of Blaine.

City of Hailey.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Luther Charles Dorsey.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. Dec. (Month) 13. (Day) 1840. (Year)

7. AGE: 76 Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Stock-grower.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa.

10. NAME OF FATHER: Chas. Dorsey.

11. BIRTHPLACE OF FATHER (State or Country) Maryland.

12. MAIDEN NAME OF MOTHER: Mary Porter.

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. E. Dorsey

(Address) Hailey, Idaho.

15. Filed Dec. 20 1916. Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1916, to Dec 16 1916, that I last saw h. alive on Dec 16 1916, and that death occured on the date stated above, at 1155 P. M.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. .....) mos. ..... ds.

(Signed) John J. Peak M. D.

12/17 1916 (Address) Hailey Idaho.

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey

DATE OF BURIAL: Dec 19 1916

20. UNDERTAKER: R. N. Harris

ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 16459
Registered No. 30

1. PLACE OF DEATH.
County of Blaine
City of Hailey
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emil E. Jansing.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 14 (Day) 1876 (Year)

7. AGE: 40 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Butcher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Harry Jansing.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Rod. J. Jansing
(Address) Hailey, Idaho.

15. Filed Dec 16 1916 Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1916, to Dec 12 1916, that I last saw him alive on Dec 12 1916, and that death occured on the date stated above, at 11.50 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of liver
(Duration) dont know Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. J. Rad M. D.
19 .... (Address) Hailey Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Westford, Mo. DATE OF BURIAL: 191-

20. UNDERTAKER: R. D. Harris ADDRESS: Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16460

Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Blaine

City of Bellevue

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21

Primary Registration District No. 2022

(No. ..... St.)

2. FULL NAME Benj. M. Davis.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. June (Month) 19 (Day) 1834 (Year)

7. AGE: 82 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Blacksmith.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio.

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs B Davis

(Address) Bellevue Ida

15.

Filed Dec. 10 1916 Robert H. Wright Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1 1916, to Dec 7 1916, that I last saw him alive on Dec 6 1916, and that death occured on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Curtis D. Byrd M. D.

19..... (Address) Bellevue Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bellevue — DATE OF BURIAL: Dec 11 1916

20. UNDERTAKER: R N Harris — ADDRESS: Hailey

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16461

Registered No. 28

1. PLACE OF DEATH.

County of Blaine

City of Hailey

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21

Primary Registration District No. 2022

2. FULL NAME Benjamin Franklin Oliver

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. July (Month) 1 (Day) 1858 (Year)

7. AGE: 78 Yrs. 6 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. Oliver

(Address) Hailey, Ida.

15. Filed Dec 5 - 1916 Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8 1916, to Dec 1 1916, that I last saw him alive on Nov 30 1916, and that death occured on the date stated above, at 11:15 A.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver and Chronic Dysentery

(Duration) Four Yrs. ..... mos. ..... ds.

Contributory (Secondary): —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. H. Kellogg M. D.

12/1 1916 (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; also in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey Idaho — DATE OF BURIAL: Dec 7, 1916

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 16463
Registered No. 33

1. PLACE OF DEATH.
County of Blaine
City of Bellevue
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Delia Black

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Feb. (Month) 26. (Day) 1841. (Year)

7. AGE: 75 Yrs. 10 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland.

10. NAME OF FATHER: John Ivers.

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Katherine York.

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Bergen
(Address) Bellevue, Ida.

15. Filed Jan 1- 1917 Robert H. Wright Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1916, to Dec 24 1916, that I last saw h.. alive on Dec 23 1916, and that death occured on the date stated above, at 7:30 A.M.
The CAUSE OF DEATH* was as follows:
Pulmonia
(Duration) 3 Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
12/26 19 16 (Signed) Austin E. Byrd M. D.
(Address) Bellevue

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellevue — DATE OF BURIAL: Dec 26 1916

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16464

Registered No. 34

1. PLACE OF DEATH.

County of Blaine

City of Hailey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21

Primary Registration District No. 2022

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Rasso

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ✓ ✓ ✓ (Month) (Day) 1 (Year)

7. AGE: about 53 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada, Nova Scotia

10. NAME OF FATHER: Alex Rasso

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Fraser

(Address) .....

15. Filed Jan 1 1917 Robert H Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec-21 1916, to Dec-29 1916, that I last saw h alive on Dec-29 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Chronic Asthma & Lobar Pneumonia

(Duration) 10 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.

12/29 1916 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey — DATE OF BURIAL: Dec 31, 1916

20. UNDERTAKER: R D Harris — ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16465
Registered No.

1. PLACE OF DEATH.
County of Lewis
City of Kamiah
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 44
Primary Registration District No. 2128
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maria Moffett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH: Don't know
(Month) (Day) (Year)

7. AGE: about 91 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housekeep.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wis-la-ta lu-tin

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Don't know.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Moffett.
(Address) Kamiah Idaho.

15. Filed 12/19 1916 W. F. McClellan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 12 (Month) . 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1916, to Dec 18 1916, that I last saw h.. alive on Dec 1st 1916, and that death occurred on the date stated above, at 4:00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 3 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. 5 mos. ..... ds.

(Signed) C. O. Bryan M. D.
12/19 1916 (Address) Kamiah Idaho,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ind. Cem. No. 2 | DATE OF BURIAL: 12/19 1916

20. UNDERTAKER: C. J. Johnson | ADDRESS: Kamiah Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 16466
Registered No. 28

1. PLACE OF DEATH.
County of Ada
City of Malad
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Wms Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH.
July (Month) 4 (Day) 1849 (Year)

7. AGE
67 Yrs. 5 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) South Wales

10. NAME OF FATHER: South Wales

11. BIRTHPLACE OF FATHER
(State or Country) Thomas Williams

12. MAIDEN NAME OF MOTHER: Annie Jones

13. BIRTHPLACE OF MOTHER
(State or Country) South Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gwenfred Jones
(Address) Malad Idaho

15.
Filed Jany 1 1917
D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1916, to Dec 31 1916, that I last saw h.s. alive on Dec 30 1916, and that death occured on the date stated above, at 5-a- M.

The CAUSE OF DEATH* was as follows:

Heart Failure superinduced by Neuralgia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. A. Allen M. D.
1/1 1917 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad, Idaho — DATE OF BURIAL: Jan. 3 1917

20. UNDERTAKER: John M. Richards — ADDRESS: Malad, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24868

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

16468

1. PLACE OF DEATH.
County of Lincoln
City of Mi. N. E. Jerome
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 1017-2017
(No. ....., ... St.)

File No. .....
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Byron R Dawson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May 15 1916 (Month) (Day) (Year)

7. AGE: 0 yrs. 9 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: L R Dawson

11. BIRTHPLACE OF FATHER (State or Country): Oklahoma

12. MAIDEN NAME OF MOTHER: Eva Myers

13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L R Dawson
(Address) Jerome

15.
Filed Jan 2 1917 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec 31 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1916., to Dec 31 1916, that I last saw him alive on Dec 31 1916, and that death occurred on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred T Schmerskall M. D.
1/31 1916 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetery | DATE OF BURIAL: Jan 2 1917

20. UNDERTAKER: D R Patterson | ADDRESS: Jerome

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 1018-2018
File No. 16469
Registered No. ____

1. PLACE OF DEATH.
County of Gooding
City of 6 Mi. N.W. Jerome
(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julia Ella Terry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Mar (Month) 1 (Day) 1915 (Year)

7. AGE: ....Yrs. 20 Mos. ....ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John A Terry

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Ruth R Daniels

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John A Terry
(Address) Appleton, Idaho

15. Filed Nov 30 1916 — E. D. Pifer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1916, to Nov 30 1916, that I last saw h....alive on Nov 30 1916, and that death occured on the date stated above, at 7P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

....(Duration) ....Yrs. ....mos. 10 ds.

Contributory (Secondary) ....

....(Duration ....yrs. ....mos. ....ds.

(Signed) E. D. Pifer M. D.

11/30 1916 (Address) Jerome

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetary — DATE OF BURIAL: Dec 2 1916

20. UNDERTAKER: Father — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24854

Form V. S. No. 5. 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16470

1. PLACE OF DEATH.

Registration District No. 23

County of Lincoln

Primary Registration District No. 1017-2017

City of ..... (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorthy Alice Knighton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH: July (Month) 27 (Day) 1915 (Year)

7. AGE: 1 yrs. 1 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: L. H. Knighton

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Hazell Leavitt

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. H. Knighton

(Address) Hendell

15. Filed Aug 27 1916 E. D. Pike Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1916, to Aug 25 1916 that I last saw her alive on Aug 24 1916 and that death occurred on the date stated above, at 10:15 A M.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) ..... yrs. 1 mos. 16 ds.

Contributory (Secondary) bronchopneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) John T. Ashmeadale M. D.

Aug 25 1916 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Jerome Ida — DATE OF BURIAL: Aug 27 1916

20. UNDERTAKER: D. A. Henriksen — ADDRESS: Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

Primary Registration District No. 2102

File No. 1

County of Minidoka

City of Rupert (No. ....., ... St.)

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mamie Rowland

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem'l

4. COLOR OR RACE: W'hite

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Sing'l

6. DATE OF BIRTH: Oct (Month) ..... (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Arthur Rowland

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Alice Sherman

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Rowland
(Address) .....

15. Filed Jan. 10 1917. V. P. Fillion, Local Registrar

MEDICAL CERTIFICATE OF DEATH 16471

16. DATE OF DEATH: Nov (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 30 1916, to ..... 191..., that I last saw h 2r alive on Nov. 30 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. P. Fillion M. D.

19.... (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery | DATE OF BURIAL: ..... 191...

20. UNDERTAKER: W. A. Goodman | ADDRESS: Rupert

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Minidoka

Primary Registration District No. 2102

File No. 16472

City of Rupert (No. ....., ... St.)

Registered No. 94

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Avis Marie Dickson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 17 (Day) 1916 (Year)

7. AGE: ..... yrs. 1 mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rupert Idaho

10. NAME OF FATHER: Lou Dickson

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Elsie Skarm

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lewis F. Dickson
(Address) .....

15. Filed Jan. 10 1917 V. P. Killen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.., to ..... 191..., that I last saw her alive on Sept 23 1916, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Tetanus

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. P. Killen M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: I O O F Cemetery — DATE OF BURIAL: Sept 26 191..

20. UNDERTAKER: W. C. Goodacre — ADDRESS: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16473

Registered No. 16

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18

Primary Registration District No. 2102

(No. ....., ... St.)

2. FULL NAME Joseph Stack

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Jan (Month) 28 (Day) 1885 (Year)

7. AGE: 30 yrs. 3 mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Patrick Stack

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Mc Ginnis

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Patrick Stack
(Address)

15. Filed Jan. 10 1917 V. P. Killen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1916, to Oct 17 1916, that I last saw h[e] alive on Oct 17 1916, and that death occurred on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. P. Killen M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Oct 17 1916

20. UNDERTAKER: W. A. Goodrum — ADDRESS: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16474

Registered No. .....

Registration District No. 6

Primary Registration District No. .....

1. PLACE OF DEATH.

County of Ada

City of Emmett

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josephine Moore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Dec (Month) 28 (Day) 1916 (Year)

7. AGE 2 days Yrs..... Mos..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Frank S Moore

11. BIRTHPLACE OF FATHER (State or Country) Lake View Ore

12. MAIDEN NAME OF MOTHER May E Ball

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F S Moore
(Address) Emmett Idaho

15.
Filed 1/2 191 7
J K Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1916, to Dec 30 1916, that I last saw h alive on Dec 30 1916, and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
atelectasis

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) B O Clark M. D.

19..... (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	12/31/1916
20. UNDERTAKER C B Buckner	ADDRESS Emmett

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNS - YORK CO., PTRS. & BKBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No.
(No. ..... , ... St.)

File No. 16475
Registered No. .....

1. PLACE OF DEATH.
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ann Burns

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Apr (Month) 11 (Day) 1831 (Year)

7. AGE: 87 Yrs. 8 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Martin Biglin

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Burns
(Address) Emmett Idaho

15. Filed 1/2 1917 J L Reynolds Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1916, to Dec 29 1916, that I last saw h[illegible] alive on Dec 28 1916, and that death occured on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J L Reynolds M. D.
1/2 1917 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 1/1 1917

20. UNDERTAKER: C D Bucknum — ADDRESS: Emmett

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16476
Registered No. .....

1. PLACE OF DEATH.
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruby Prescilla Reese

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child
6. DATE OF BIRTH. Jan (Month) 17 (Day) 1908 (Year)
7. AGE: 8 Yrs. 11 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Edd. Reese
11. BIRTHPLACE OF FATHER (State or Country): Wales
12. MAIDEN NAME OF MOTHER: Mary Farmer
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.
(Informant) O. F. Reese
(Address) Emmett Idaho
15. Filed 1-2 1917
J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 16 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 1913, to Dec 17 1916, that I last saw h[illegible] alive on Dec 17 1916, and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Epilepsy
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) O. F. Clark M. D.
19..... (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 12/27/1916
20. UNDERTAKER: O. D. Bucknum — ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16477

Registered No. .....

Registration District No. 6

Primary Registration District No. .....

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Evans

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower

6. DATE OF BIRTH. Apr (Month) 20 (Day) 1850 (Year)

7. AGE: 66 Yrs. / Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Charles Evans

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward V. Evans
(Address) Emmett Ida

15. Filed 1/2 191?

J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1915, to 12/12 1916, that I last saw him alive on 12/12 1916, and that death occured on the date stated above, at 11 a. M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Chronic nephritis

(Duration) Several yrs. mos. ds.

Contributory (Secondary) Arterio-sclerosis

(Duration) ? yrs. mos. ds.

(Signed) [illegible] M. D.

12/13 1916 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	12/13 1916
20. UNDERTAKER C. D. Bucknum	ADDRESS Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16478

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6

Primary Registration District No. .....

(No. ....., ... St.)

2. FULL NAME Mary Daisy Creswell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Wife

6. DATE OF BIRTH. June (Month) 18 (Day) 1903 (Year)

7. AGE: 13 Yrs. 5 Mos. 22 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. A. Creswell

11. BIRTHPLACE OF FATHER (State or Country): ~~Idaho~~ Iowa

12. MAIDEN NAME OF MOTHER: Daisy Strohbehn

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. Creswell

(Address) Emmett Idaho

15. Filed 12/11 1916

J. L. Reynolds
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1916, to Dec 10 1916, that I last saw h.. alive on Dec 10 1916, and that death occured on the date stated above, at 3-P M.

The CAUSE OF DEATH* was as follows:

Mitral Valvular Leakage

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute Dilitation of Heart

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Reynolds M. D.

12/11 1916 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho

DATE OF BURIAL: 12/12 1916

20. UNDERTAKER: C. D. Bucknum

ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16479

Registered No. 47

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Payette

2. FULL NAME Arnold Stetson Norris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. January (Month) 4th (Day) 1912 (Year)

7. AGE: 4 Yrs. 11 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho, Washington County

10. NAME OF FATHER: John H. Norris

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Louise Kummer

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Norris

(Address) Payette, Idaho

15. Filed June 1 1917 F.R.W. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1916, to Dec 31 1916, that I last saw h[illegible] alive on Dec 31 1916, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) ..... Yrs. 7 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F.R.W. Woodward M. D.

1/1 1917 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: Jan 3 1917

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & RDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16480
Registered No. .....

Registration District No. .....
Primary Registration District No. .....

1. PLACE OF DEATH.
County of Custer
City of Challis
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Philps.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. June 26 (Month) (Day) 1846 (Year)

7. AGE: 70 Yrs. 5 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... First Miner then
(b) General nature of industry, business, or establishment in which employed (or employer)..... farming.

9. BIRTHPLACE (State or Country) Tarok Shire Scotland

10. NAME OF FATHER Robert Philps.

11. BIRTHPLACE OF FATHER (State or Country) Tarok Shire Scotland.

12. MAIDEN NAME OF MOTHER Helen Frew

13. BIRTHPLACE OF MOTHER (State or Country) Kilmarnock Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert W. Philps.
(Address) Challis Idaho

15.
Filed ..... 191....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) Second. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1916, to Dec 2 1916,
that I last saw him alive on 1916,
and that death occured on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:
an acute attack of Lodiff and a return of his old complint asthma which he had at intervals for 35 years
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) R. W. Philps D.D. M. D.
19..... (Address) Challis Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 26 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Tarok Shire Scotland
Former or usual residence Idaho Falls Idaho

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOOK. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16481
Registered No.

1. PLACE OF DEATH.
County of Custer
City of Challis
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth Louese Bursted

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
F	Wh.	Single

6. DATE OF BIRTH: July (Month) 26th. (Day) 1916 (Year)

7. AGE: 1 yrs. 4 mos. 12 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Custer

10. NAME OF FATHER Seth Bursted

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Mollie Drake

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Sarrah Drake
(Address) Challis, Idaho

15.
Filed ..... 191 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec. (Month) 7th. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 5th 1916, to Dec. 7th. 1916, that I last saw her alive on Dec. 7th 1916, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Kirby M. D.
19 ..... (Address) Challis, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Challis	Dec. 8tt 191 6
20. UNDERTAKER	**ADDRESS**
Family	Challis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16482

Registered No.

1. PLACE OF DEATH.

County of Custer

City of Challis

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Jennie Dodge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	Wh.	Widowed

6. DATE OF BIRTH

Not known (Month) 1 (Day) (Year)

7. AGE

73 yrs. mos. ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Maine

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER

(State or Country) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER

(State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank McPherson

(Address) Challis Ida

15.

Filed 191 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

12 (Month) 1st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/19 1916., to 12/1 1916., that I last saw her alive on 12/1 1916., and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia
following grip and hemorrhage
from lungs

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. E. Hurley M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Challis	12/3 1916
20. UNDERTAKER	ADDRESS
H. D. Williams	Challis

SYMS - YORK CO., PTRS. & SDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Registration District No. ____

Primary Registration District No. ____

City or ____ (No. ____ St.) Registered No. ____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Helen Mayhew

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov. (Month) 26 (Day) 1916 (Year)

7. AGE ....Yrs....Mos....ds. IF LESS than 1 day how many 1½ hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ~
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ada Co. Idaho

10. NAME OF FATHER Clarence Mayhew

11. BIRTHPLACE OF FATHER (State or Country) Ida.

12. MAIDEN NAME OF MOTHER Myrtle McGeoff.

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Clarence Mayhew
(Address) Meridian Idaho

15. Filed Nov. 27th 1916 C. L. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 27th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27th 1916, to Nov 26. 1916, that I last saw h[illegible] alive on Nov 26 1916, and that death occured on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:
Failure of valve in heart to close.

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. F. Neal M. D.

Nov 26 1916 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Idaho — DATE OF BURIAL: Nov 27 1916

20. UNDERTAKER: W. S. Mater Meridian — ADDRESS: Idaho

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 822
Primary Registration District No. 2078
File No. 16485
Registered No. 20

1. PLACE OF DEATH.
County of Shoshone
City of Clarkia
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert H Corwin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Aug. (Month) 18 (Day) 1885 (Year)

7. AGE
31 Yrs. 3 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Nebraska

10. NAME OF FATHER: W. W. Corwin

11. BIRTHPLACE OF FATHER
(State or Country) Ill.

12. MAIDEN NAME OF MOTHER: Hannah Aleshire

13. BIRTHPLACE OF MOTHER
(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David Corwin
(Address) Spokane Wash.

15.
Filed Dec 8 1916 W. C. Mowry Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 4 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
accidently Struck by Log.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) Chas. Mowery Coroner M. D.
12/7 1916 (Address) Wallace Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Coteau Field Neb. DATE OF BURIAL: 12/8 1916

20. UNDERTAKER: H E Hunt ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 228
(No. Cale Creek North Fork)

File No. 16486
Registered No. 91

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Jacobson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 52 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anton Tajurel
(Address) Enaville Ida

15. Filed Dec 10 1916 W. H. Mowery Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Alcoholism
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. R. Mowery Coroner
Dec 10 1916 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: 12-9 1916

20. UNDERTAKER: Bruce G. Mantle — ADDRESS: Wallace

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 12

Primary Registration District No. 2200

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16487

Registered No. 227

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. Sassafrack Ave St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur Bradford Lunara

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. February (Month) 2 (Day) 1878 (Year)

7. AGE: 38 Yrs. 10 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Edgar R Lunara

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Bradford

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Glenn L Lunara

(Address) Sunset Idaho

15. Filed Dec 20 1916 H A Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1916, to Dec 16 1916, that I last saw him alive on Dec 14 1916, and that death occured on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary) La Grippe & Exposure

(Duration) yrs. mos. 16 ds.

(Signed) Dr. M. D.

12/16 1916 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL: 12/17 1916

20. UNDERTAKER: Bruce G Rhodes — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16488

Registered No. 2

1. PLACE OF DEATH.

County of ~~Oxford~~ Bannock Registration District No. 11

City of Oxford (No. .... St.) Primary Registration District No. 2046

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cora Boyce Helmandollar

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. May (Month) 17 (Day) 1916 (Year)

7. AGE: ..... Yrs. 7 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bannock Co. Idaho

10. NAME OF FATHER George Helmandollar

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Nellie Leonard Boyce

13. BIRTHPLACE OF MOTHER (State or Country) Bannock County Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Hatch

(Address) Oxford Idaho

15. Filed Jan 10 1917 Essie McCoy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 4 1916, to Dec 11 1916, that I last saw h.er alive on Dec 9 1916 and that death occured on the date stated above, at 6—A M.

The CAUSE OF DEATH* was as follows:

Malignant Erysipelas.

..... (Duration) 6 Yrs. 6 mos. 8 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) G W Slate M. D.

Dec 11 1916 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oxford Idaho — DATE OF BURIAL: Dec 13 1916

20. UNDERTAKER: none — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

Informant, Funeral Director, Registrar and Medical Attendant, EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215). Address correspondence to State Bureau of Vital Statistics, Boise, Idaho.

United States
Department of Commerce
Bureau of the Census

AMENDED

Certificate Of Death

December 5, 1946 STATE OF IDAHO

State File No. 16489
Local Reg. No. 3
Reg. Dist. No. 2048

1. **PLACE OF DEATH:**
   (a) County Bannock
   (b) City or town Thatcher
   (c) Street Address or R. F. D. No. .....
   (d) Death Occured Inside? ..... Outside? ..... city or town
   (e) Died in a Home .... Hospital .... Institution .... Other place ....
   (f) Name Hosp. or Inst. ..... Stayed ..... days
   (g) Lived in this county ..... years ..... months ..... days

Note. For a person residing in THIS county LESS than 1 year, give FORMER residence under item 2.

2. **Usual Residence of Deceased:** (Always fill in these)
   (a) State Idaho (b) County .....
   (c) City or town .....
   (d) Street Address or R.F.D. No. .....
   (e) Deceased lived Inside? ..... Outside? ..... city or town
   (f) Citizen of what country? .....
   (g) How long had deceased lived in Idaho? ..... years
   (h) Former residence (city, state) .....

3. (a) **FULL NAME** Joseph Hiram Bevins

3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Date of Birth (Month, Day, Year) September 30, 1846

8. AGE	Years	Months	Days	If less than 1 day
	70	1	14	hrs ... min.

9. Exact Occupation Clerk of Stake — Did this work for ..... yrs.
10. Industry or Business L. D. S. Church — Date last worked .....
11. Birthplace Ontario, Canada (City or town) (State or foreign country)

Father
12. Name Peter Bevins
13. Birthplace New York (City or town) (State or foreign country)

Mother
14. Maiden name Mary Bevins
15. Birthplace New York (City or town) (State or foreign country)

16. Informant's **OWN** Signature Henry Thatcher
and Address Thatcher, Idaho

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Nov. 16, 1916 (Month) (Day) (Year)
(c) Place: Thatcher, Idaho

18. Funeral Director's **OWN** Signature S. Baldunkle
and Address Thatcher, Idaho

19. (a) Ded. 10, 1916 (Date received and filed) (b) Ellis Kackley (Registrar's signature)

MEDICAL CERTIFICATE OF DEATH

20. **DATE OF DEATH** (Month, Day, Year) Nov. 14, 1916
at 4 o'clock A M.

21. **I HEREBY CERTIFY**, That I attended deceased from Aug. 10 1916, to Nov. 14 1916
I last saw him alive on Nov. 14, 1916; death is said to have occurred on the date and hour stated above.

Immediate Cause of Death:	Duration
Carcinoma of Liver	1 yr
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Where was disease contracted? .....
Name of operation ..... Date .....
Major finding .....
Finding of autopsy .....

PHYISICIAN Underline the cause to which death should be charged statistically.

22. If death was due to **EXTERNAL CAUSES**, also fill in the following: Accident? ..... Suicide? ..... Homicide? .....
Occurred ..... 19 ..... City, county, state where violence occurred .....
Place of Violence: Home ..... Farm ..... Industry .....
Public Place ..... While at work? .....
Means of injury .....

23. Attendant's **OWN** Signature Ellis Kackley M. D. (M. D. or other)
and Address Thatcher, Date ..... 19 .....
(For additional space, use reverse side)

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2048
File No. 16489
Registered No. 3

1. PLACE OF DEATH.
County of Bannock
City of Thatcher (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Bevins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept. (Month) 30th (Day) 1846 (Year)

7. AGE: 70 Yrs. 1 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk of Stake
(b) General nature of industry, business, or establishment in which employed (or employer): L.D.S Church

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Peter Bevins

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mary Bevins

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry Thatcher
(Address) Thatcher, Ida

15. Filed Dec. 10, 1916 Chas. Curry Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 14, (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1916, to Nov 14 1916, that I last saw h[illegible] alive on Nov 12 1916, and that death occured on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows: Carcinoma of Larynx

(Duration) 1 Yrs. — mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Curry M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Thatcher, Ida — DATE OF BURIAL: Nov 16 1916

20. UNDERTAKER: Ind Budenick — ADDRESS: Thatcher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH—BUREAU OF VITAL STATISTICS

AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE OF BIRTH OR DEATH

State of Idaho } ss.
County of Bannock }

Certificate No. 16489 death

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of (Birth or Death) for John Bevins (Name on Original Certificate) who (Was Born or Died) on (Date of Event) in (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Name	John Bevins	Joseph Hiram Bevins
Birthplace	New York	Ontario, Canada

Subscribed and sworn to before me this 2 day of December, 19 46

Notary Public, residing at Grace, Idaho.

My commission expires 1-19-49

(Seal)

Signed [signature] (Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Grace, Idaho. (Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Bannock }

[This Affidavit **MUST** Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 2nd day of December, 19 46

Notary Public, residing at

My commission expires 1-19-49

(Seal)

Signed [redacted] L. H. Merrill (Signature of Any Credible Person)

Box 100 (Street Address, City, State)

Grace, Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Id... BOARD OF H... Bureau of Vital ...

1. PLACE OF DEATH.

Registration District No. 11

County of Bonneville

Primary Registration District No. 2048

File No. 1645

City of Thurlicher

(No. .... St.)

Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jeppa Falkman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec 16 (Month) (Day) 1824 (Year)

7. AGE 91 Yrs. 11 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Åkersagn Denmark

10. NAME OF FATHER Jørgen C. Falkman

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Gertrude Iversen

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harold Thurlicher

(Address) Thurlicher, Idaho

15.

Filed Nov 21, 1916 — Eric Kenley, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 21, (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 9.15 A.M.

The CAUSE OF DEATH* was as follows:

Senile Decay

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eric Kenley M. D.

Nov 21 1916 (Address) Sand Springs, Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Thurlicher, Id	Nov 23 1916
20. UNDERTAKER	ADDRESS
Lund Redmond	Thurlicher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16491
Registered No. 43

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W Noble

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced
6. DATE OF BIRTH. October 4th 1860 (Month) (Day) (Year)
7. AGE: 56 Yrs. 2 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Scotland
10. NAME OF FATHER: Do not know
11. BIRTHPLACE OF FATHER (State or Country): " " "
12. MAIDEN NAME OF MOTHER: " " "
13. BIRTHPLACE OF MOTHER (State or Country): " " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. C. Moeller
(Address) Salmon Ida
15. Filed Dec 16 1916 E D Herndon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 13th 1916 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1916, to Dec 15th 1916, that I last saw h[im] alive on Dec 13 1916, and that death occured on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Hemorrhage in Brain
(Contributory) (Secondary) (Duration) 1 Yrs. mos. 20 ds.
.....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) F S Wright M. D.
Dec 15 1916 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: William C Moeller — DATE OF BURIAL: 12-17" 1916
20. UNDERTAKER: Salmon Cemetery — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PYRS. & SONS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16492

Registered No. 144

1. PLACE OF DEATH.

County of Lemhi

City of Salmon

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert William McBride

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April 22" (Month) (Day) 1860 (Year)

7. AGE: 52 Yrs. 7 Mos. 22 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Mining +

(b) General nature of industry, business, or establishment in which employed (or employer)..... Real Estate

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (State or Country) " " "

12. MAIDEN NAME OF MOTHER " " "

13. BIRTHPLACE OF MOTHER (State or Country) " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kenneth C McBride

(Address) Salmon Idaho

15.

Filed Dec 15 1916 E D Henderson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1916, to Dec 14 1916, that I last saw h[illegible] alive on " 13 1916, and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

[illegible]

(Duration) ath 7 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Dec 15 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 1-15-17 1916

20. UNDERTAKER: William C Hall — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 16493
Registered No. 42

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Walter Trued

N. B.—Every item of information should be carefully supplied. Ages should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July 21 (Month) (Day) 1872 (Year)

7. AGE: 44 Yrs. 3 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Liveryman
(b) General nature of industry, business, or establishment in which employed (or employer): Do not know

9. BIRTHPLACE (State or Country): Cherokee Co. Iowa

10. NAME OF FATHER: Do not Know

11. BIRTHPLACE OF FATHER (State or Country): Joe Davis. Illinois

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Canton, Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Mrs. Jane Trued Ida.

15. Filed Dec. 6 1916 E. D. Hendrix Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 3rd (Month) Sunday (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1916, to Dec 3rd 1916, that I last saw him alive on Dec 3 1916, and that death occured on the date stated above, at 10.30 A.M.

The CAUSE OF DEATH* was as follows:
Tubercle of lung
r
About 8 months (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia
auricularis
(Duration 2 yrs. ..... mos. ..... ds.
(Signed) Chas F. Hanner M. D.
19..... (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Idaho. DATE OF BURIAL: Dec 6 1916

20. UNDERTAKER: W C Hoobler ADDRESS: Salmon Ida

SYMS - YORK CO., PTRS. & BOBS. 24658

FORM V. S. No. 6-16 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 16494
(No. ....., ... St.) Armamedrud
Registered No. 44

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Child of Arne Amedonud

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec. (Month) 22 (Day) 1916 (Year)

7. AGE: 2 Hours ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kootenai Idaho

10. NAME OF FATHER Arne Amedonud

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Ester Pedersen

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arne Amedonud
(Address) 1204 Coeur d'Alene

15. Filed 12-27 1916 H. Hughes, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 22 1916, to ..... 191..., that I last saw h[illegible] alive on Dec. 22 1916, and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Byers M. D.
Dec. 22 1916 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Dec. 23 1916

20. UNDERTAKER: J. E. Kredal — ADDRESS: C.D.A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & STNR. 24958

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 76495
Registered No. 43.

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William H. Caldwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married ~~Widowed~~

6. DATE OF BIRTH: June (Month) 1 (Day) 1830 (Year)

7. AGE: 86 Yrs. 6 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): ~ ~

12. MAIDEN NAME OF MOTHER: Mary Smith

13. BIRTHPLACE OF MOTHER (State or Country): ~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed 12-30 1916 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 29th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1916, to Dec 29 1916, that I last saw him alive on Dec 25 1916, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jno Bunby M. D.

19..... (Address) Coeur D'alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Dec. 31 1916

20. UNDERTAKER: T. C. Hudel — ADDRESS: C. D. A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & STDS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 16496
Registered No. 41

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elisabeth M. Tompkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Sept (Month) 23 (Day) 1857 (Year)

7. AGE: 64 Yrs. 2 Mos. 27 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Ira Ward

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Charlotte Jeffords

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lottie George
(Address) .....

15. Filed 12-21 1916 — A. Hughes, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 20th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1916, to December 18 1916, that I last saw her alive on December 18th 1916, and that death occured on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:
Bright's Disease
.....(Duration) — Yrs. 7 mos. — ds.
Contributory (Secondary) General Anasarca
.....(Duration — yrs. 7 mos. — ds.

(Signed) Alexander Carson M. D.
12-22 1916 (Address) 611 Garden Ave, Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Dec 21 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16497

Registered No. 40

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29

Primary Registration District No. 1056

(No. ....., ... St.)

2. FULL NAME Job Wilbur

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	Married

6. DATE OF BIRTH.

2 (Month) 4 (Day) 1846 (Year)

7. AGE

70 Yrs. 10 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Wilbur

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. A. Wilbur

(Address) .....

15.

Filed 12-26 1916

A. Hughes
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1916, to Dec 24 1916, that I last saw him alive on Dec 25 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Apoplexy following La Grippe

(Duration) ..... Yrs. 1 mos. 4 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jno Bunby M. D.

19.... (Address) Coeur d'Alene.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetary	Dec 27 1916
20. UNDERTAKER	**ADDRESS**
Cassedy & Nelson	Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16498

Registered No. 39

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D'Alene

Registration District No. 29

Primary Registration District No. 1050

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Archibald Cook

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Jan (Month) 6 (Day) 1833 (Year)

7. AGE 83 Yrs. 11 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER D. Cook

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas A Cook

(Address) .....

15. Filed 12-30-1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 19 1916, to Dec. 29 1916, that I last saw h[illegible] alive on Dec. 28 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Lumbago

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Wright M. D.

Dec 29 1916 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Dec 31 1916

20. UNDERTAKER: Cassedy & Nelson — ADDRESS: Coeur D'Alene

SYMS - YORK CO., PTRS. & BOES. 24858

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No. 29

Primary Registration District No. 1050

(No. ....., ... St.)

File No. 16499

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edgar D Delavan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 70 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N.Y

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Irvin C. Delavan

15. Filed Dec 18 1916

J. F. Hughes
Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1916, to Dec 16 1916, that I last saw h m alive on Dec. 16 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Chole cystitis

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

(Duration ..... yrs ..... mos. ..... ds.

(Signed) J. C. Thayer M. D.

12/16 1916 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest — DATE OF BURIAL: Dec 18 1916

20. UNDERTAKER: J. F. Green — ADDRESS: C d A

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D'Alene

Registration District No. 29

Primary Registration District No. 1050

(No. ....., ... St.)

File No. 16500

Registered No. 96.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy G. Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH. Dec. (Month) 23 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Coeur D'Alene Ida

10. NAME OF FATHER L. E. Jones

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Eva Byers

13. BIRTHPLACE OF MOTHER (State or Country) Troy Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lonnie E. Jones

(Address) Coeur d'Alene Ida

15. Filed Dec-25 1916 D. Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1916, to Dec 24 1916, that I last saw h alive on Dec. 24 1916, and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Not known

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Clayton M. D.

Dec. 26 1916 (Address) Coeur d'Alene, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetary	Dec 25 1916
20. UNDERTAKER	**ADDRESS**
Cassedy & Nelson	Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. [illegible] M

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 29

Primary Registration District No. 1050

File No. 16501

County of Kootenai

City of Coeur d'Alene (No. [illegible], [illegible] St.)

Registered No. 35

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vincent Sum of W M Cathcart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): —

6. DATE OF BIRTH. [illegible] 1 [illegible] (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W M Cathcart

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Edmonia Wiggins

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W M Cathcart

(Address) C D A

15. Filed 12-23 1916 O. A. Hughes Local Registrar

SYMS - YORK CO., PTRS. & SRRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 21 1916, to Dec 22 1916, that I last saw him alive on Dec. 22 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Probably prolonged and difficult birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Hughes M. D.

12/23 1916 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest — DATE OF BURIAL: Dec 23 1916

20. UNDERTAKER: S. J. Lucas — ADDRESS: C D A

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147
Primary Registration District No. 67
File No. 16502
Registered No. 34

1. PLACE OF DEATH.
County of Latah
City of Avon
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louisiana Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Oct. (Month) 8 (Day) 1840 (Year)

7. AGE: 76 yrs. 2 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: H. W.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Louisiana

10. NAME OF FATHER: J. M. Fuller

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Jane Hurst

13. BIRTHPLACE OF MOTHER (State or Country): Conn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant):
(Address) B. F. Smith

15. Filed 12-15 1916 P. V. Faust
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw h— alive on — 191..., and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows: Old age reported

— (Duration) — yrs. — mos. — ds.
Contributory Cold
(Secondary)
— (Duration) — yrs. — mos. 21 ds.

(Signed) — M. D.
— 19.... (Address) —

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Avon Cemetery
DATE OF BURIAL: 12/19 1916

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 120
Primary Registration District No. 2199
File No. 16503
Registered No. .....

1. PLACE OF DEATH.
County of Cassia
City of Oakland
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elaine Wahlstrom

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH.
Feb. (Month) 14 (Day) 1916 (Year)

7. AGE
..... Yrs. 1 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... baby.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Oakland

10. NAME OF FATHER Albert W Wahlstrom

11. BIRTHPLACE OF FATHER
(State or Country) Sweden

12. MAIDEN NAME OF MOTHER Beda Hoagg

13. BIRTHPLACE OF MOTHER
(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert Wahlstrom
(Address) c.....

15.
Filed 1-30 1917 Florence Dahlquist
Local Registrar

SVMS - YORK CO., PTRS. & BOBS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1916, to Dec 29 1916, that I last saw h. alive on Dec 29 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

1/3, 1917 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakland | DATE OF BURIAL: 1-2 1917

20. UNDERTAKER: Harvey Sleeman | ADDRESS: Nampa

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16504
Registered No.

1. PLACE OF DEATH.
County of
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.

2. FULL NAME Dora Green

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 20 (Day) 1916 (Year)

7. AGE: ....yrs. ....mos. 3 hours ds. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Oakley, Idaho

10. NAME OF FATHER: Chas. T. Green

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Nora Williams

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. O. Nielson
(Address) Oakley, Idaho

15. Filed 1-30 1917 Florence Dahlquist Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 7 1916, to Dec 20 1916, that I last saw h[illegible] alive on Dec 20 1916, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Pneumonia Chill

(Duration) ....yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. O. Nielson M. D.

19.... (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sunset Cemetery — DATE OF BURIAL: Dec 21 1916

20. UNDERTAKER: Paul J. Black — ADDRESS: Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

Primary Registration District No. 2119

File No. 16505

County of Franklin

City of Mink Creek (No. ....., ... St.)

Registered No. 52

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lester Thorsteson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W hite

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Febr. 16 1914 (Month) (Day) (Year)

7. AGE: 2 Yrs. 10 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: child -
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho - U S A.

10. NAME OF FATHER: Henry Christensen

11. BIRTHPLACE OF FATHER (State or Country): Mink Creek, Idaho

12. MAIDEN NAME OF MOTHER: Serena Hammersmark

13. BIRTHPLACE OF MOTHER (State or Country): Norway -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas Jepsen
(Address) Mink Creek Idaho

15. Filed Dec 26 1916 Oak Cullen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 24 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1916, to Dec. 24 1916, that I last saw him alive on Dec. 21 1916, and that death occured on the date stated above, at 9.30 a M.

The CAUSE OF DEATH* was as follows:
Pneumonia (Broncho following measles -
(Duration) ✓ Yrs. ✓ mos. 10 - ds.
Contributory (Secondary) Measles
(Duration ..... yrs. 1 mos. ..... ds.
(Signed) G W Stalks M. D.
Dec. 26 1916. (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mink Creek, Idaho, — DATE OF BURIAL: Dec. 27 1916

20. UNDERTAKER: Skidmore — ADDRESS: Preston Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 16506
Registered No. 57

1. PLACE OF DEATH.
County of Franklin
City of Preston
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Christina Larsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: [illegible]

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug. (Month) 15 (Day) 1880 (Year)

7. AGE: 36 Yrs. 1 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Christian Sorensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Dorthea Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jens P Larsen
(Address)

15.
Filed Oct 11 1916 Dora Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1916, to Oct 10 1916, that I last saw h[illegible] alive on Oct 3 1916, and that death occured on the date stated above, at 12:10 P.M.

The CAUSE OF DEATH* was as follows:
Mitral and Tricuspid In-sufficiency
(Duration) Many Yrs. mos. ds.
Contributory (Secondary) Rheumatism and Chiel hearing
(Duration) yrs. mos. ds.
(Signed) Curtis Bland M. D.
10/11/1916 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho
DATE OF BURIAL: Oct 12 1916

20. UNDERTAKER: W. A. Skidmore
ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16507
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Dingle

Registration District No. 52
Primary Registration District No. 2130
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Baby Sparks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH: 10 (Month) 9 (Day) 1916 (Year)

7. AGE: — yrs. 1 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Dingle Ida

10. NAME OF FATHER: Ernest Sparks

11. BIRTHPLACE OF FATHER (State or Country): U S.

12. MAIDEN NAME OF MOTHER: Louie Humphries

13. BIRTHPLACE OF MOTHER (State or Country): U S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Sparks
(Address) Dingle Ida.

15.
Filed 11-20 1916
E. F. Gwyn
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 11 (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1916, to Nov 19 1916
that I last saw her alive on Nov 19 1916
and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) — yrs. — mos. 2 ds.

Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.

(Signed) Miss N. Bagley Nurse M. D.
11-20 1916 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dingle Ida
DATE OF BURIAL: 11-21 1916

20. UNDERTAKER: None
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16508

Registered No. ____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Custer

City of Clayton

(No. ____, ____ St.)

Registration District No. ____

Primary Registration District No. ____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kenneth Hoesinger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: November 25
(Month) (Day)

7. AGE: 75 yrs. 7 mos. ____ ds.

IF LESS THAN ONE DAY, how many ____ minutes

8. OCCUPATION
(a) Trade, professsion, or particular kind of work ____
(b) General nature of industry business, or establishment in which employed (or employer) Laborer

9. BIRTHPLACE (State or Country) Baden [illegible]

10. NAME OF FATHER Paul Koesinger

11. BIRTHPLACE OF FATHER (State or Country) Baden, Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____

(Address) ____

15.

Filed ____ 191__ ____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 27 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 191__, to ____ 191__

that I last saw h____ alive on ____ 191__,

and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Drowned in Salmon River

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) ____ M. D.

____ 19__ (Address) ____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

Place ____ In the

Death ____ yrs. ____ mos. ____ ds. State ____ yrs. ____ mos. ____ ds.

Where was Disease contracted,

if not at place of death? ____

Former or

usual residence ____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL July 27 1916

UNDERTAKER

ADDRESS

J. W. Ebbert, Coroner

M. B.—Every item should be filled in plain terms, so that it may be properly classified. Must state CLAIMS should state CAUSE OF DEATH. FAILURE ment of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16509

Registered No.

1. PLACE OF DEATH.
County of Canyon
City of New Plymouth (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.

2. FULL NAME James H Patton

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: June (Month) 4 (Day) 1838 (Year)

7. AGE: 78 yrs. 5 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nova Scotia

10. NAME OF FATHER: — Patton

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. S. Stuart
(Address) New Plymouth

15.
Filed 11-30 1916 Wm J. Drysdale Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9 1916., to Nov 29 1916, that I last saw h(im) alive on Nov 28 1916, and that death occurred on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:
Obstructed Jaundice from gall stones - Cancer of liver - months (Duration) yrs. mos. ds.
Contributory (Secondary) Debility - (Duration) yrs. mos. ds.

(Signed) Wm J. Drysdale M. D.
11-30 1916 (Address) New Plymouth

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Falk Ida — DATE OF BURIAL: Dec 1 1916

20. UNDERTAKER: ~~D H Cassad~~ A Meyer — ADDRESS: ~~Boyette~~ Ida New Ply

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16510
Registered No. 56

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No. ....., ... St.)
Registration District No. 26
Primary Registration District No. 2069
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace E. Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 12 (Day) 1915 (Year)

7. AGE: 1 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Malad, Idaho

10. NAME OF FATHER David E. Jones

11. BIRTHPLACE OF FATHER (State or Country) Malad, Idaho

12. MAIDEN NAME OF MOTHER Catherine J Evans

13. BIRTHPLACE OF MOTHER (State or Country) Malad, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David E Jones
(Address) Malad

15. Filed Dec 25 1916 — Local Registrar

SVMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1916, to ..... 191..., that I last saw h[illegible] alive on Dec 24 1916, and that death occured on the date stated above, at 11:20 P.M.
The CAUSE OF DEATH* was as follows:
Influenza
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. 3 ds.
(Signed) D C Ray M. D.
1/25 1916 (Address) Malad City Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad, Idaho — DATE OF BURIAL: 12-27 1916

20. UNDERTAKER: J M. Richards — ADDRESS: Malad Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
(No. .... St.)

File No. .....
Registered No. 16511

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Gooding
City of Woodruff
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Ashton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. March 25 (Month) (Day) 1829 (Year)

7. AGE: 87 Yrs. 9 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Robert Ashton

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Maria Liptrot

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jas Ashton
(Address) Woodruff, Idaho.

15. Filed 12-28 1916 — Dr C Ray, Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 8 a M.
The CAUSE OF DEATH* was as follows:
Old age
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) Jas O'Harrison Corner M. D.
12/28/1916 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portage, Utah — DATE OF BURIAL: Dec. 30 1916

20. UNDERTAKER: Jos Richards — ADDRESS: Malad, Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Oneida

City of Malad

Registration District No. 26

Primary Registration District No. 2069

(No. ....., ... St.)

File No. 16512

Registered No. 55

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Howard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 29 (Day) 1912 (Year)

7. AGE: 4 Yrs. 7 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bountiful Utah

10. NAME OF FATHER: William J. Howard

11. BIRTHPLACE OF FATHER (State or Country): Bountiful Utah

12. MAIDEN NAME OF MOTHER: Rosanna Oliver

13. BIRTHPLACE OF MOTHER (State or Country): Bountiful Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm J. Howard

(Address) Malad Idaho

15. Filed 12-26 1916

D C May
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-21 1916, to 12-24 1916, that I last saw her alive on 12-24 1916 and that death occured on the date stated above, at 3:35 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D C May M. D.

12-26 1916 (Address) Malad City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bountiful Utah — DATE OF BURIAL: 12-27 1916

20. UNDERTAKER: J M Richards — ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED. FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16514

Registered No. 53

1. PLACE OF DEATH.

County of Oneida

City of Malad

Registration District No. 7

Primary Registration District No. 2069

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura Baker Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 11 (Day) 1880 (Year)

7. AGE: 36 Yrs. 6 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Meadow, Utah

10. NAME OF FATHER: Albert M. Baker

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Edna Jane Coon

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Peter Jensen

(Address) Malad

15. Filed Dec 17 1916

D. C. Kay
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1916, to Dec 16 1916, that I last saw her alive on Dec 15 1916, and that death occured on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) Yrs. 3 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) D. C. Kay M. D.

12-17 1916 (Address) Malad City Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Brigham City, Utah — DATE OF BURIAL: 12-19 1916

20. UNDERTAKER: Ira M. Richards — ADDRESS: Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16515

Registered No. 57

1. PLACE OF DEATH.

Registration District No. 26

Primary Registration District No. 2069

County of Oneida

City of Pleasantview (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret A. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. October (Month) 6 (Day) 1892 (Year)

7. AGE: 24 Yrs. 1 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malad - Idaho

10. NAME OF FATHER: Ed. Vaughan

11. BIRTHPLACE OF FATHER (State or Country): Malad, Idaho

12. MAIDEN NAME OF MOTHER: Emily John

13. BIRTHPLACE OF MOTHER (State or Country): Portage, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Parley Olsen
(Address) Pleasantview Idaho

15. Filed Dec 6 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1916, to Dec 4 1916, that I last saw h[illegible] alive on Dec 4 1916, and that death occured on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
Acute Nephritis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) pulmonary tuberculosis

(Duration yrs. mos. ds.

(Signed) L. C. Ray M. D.

12/6 1916 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad, Idaho — DATE OF BURIAL: Dec. 7 1916

20. UNDERTAKER: John M. Richards — ADDRESS: Malad, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-43

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16518
Registered No. 45

1. PLACE OF DEATH.
County of Oneida
City of Samaria
(No. ....., ... St.)
Registration District No. 26
Primary Registration District No. 2069
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emelia Waldron

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. February 14 1914 (Month) (Day) (Year)

7. AGE: 2 Yrs. 9 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Samaria Idaho

10. NAME OF FATHER: Levi G. Waldron

11. BIRTHPLACE OF FATHER (State or Country): Samaria Idaho.

12. MAIDEN NAME OF MOTHER: Eliza S. Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Levi G Waldron
(Address) Samaria Idaho.

15. Filed 11-16 1916 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November February 15 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1916, to Nov 15 1916, that I last saw her alive on Nov 15 1916 and that death occured on the date stated above, at 2.50 P.M.

The CAUSE OF DEATH* was as follows: Accidental burns

(Duration) ..... Yrs. ..... mos. 11 ds.
Contributory (Secondary) Septicemia
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D C Kay M. D.
11-16 1916 (Address) Malad City, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Samaria Idaho
DATE OF BURIAL: Nov. 17 1916

20. UNDERTAKER: J McPherson
ADDRESS: Malad, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTYS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 16519
Registered No. 46

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No. ....., ..., St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel P. Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
August 23 1875
(Month) (Day) (Year)

7. AGE
41 Yrs. 2 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Barber
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Malad Idaho

10. NAME OF FATHER: Caleb P. Jones

11. BIRTHPLACE OF FATHER
(State or Country) Wales

12. MAIDEN NAME OF MOTHER: Eliza Roberts

13. BIRTHPLACE OF MOTHER
(State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Celia Jones
(Address) Malad City Ida

15.
Filed 11-18 1916
L. Clay
Local Registrar

SYMS - YORK CO., PTRS. & MDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. 16 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 1 1916, to Nov 16 1916, that I last saw him alive on Nov 15 1916, and that death occured on the date stated above, at 3:15 A.M.

The CAUSE OF DEATH* was as follows:
Chronic pleurisy

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute insufficiency
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L Clay M. D.
11-18 1916 (Address) Malad City Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad, Idaho — DATE OF BURIAL: Nov. 18 1916

20. UNDERTAKER: John McRichard — ADDRESS: Malad Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 16520
Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Reeder Metcalf

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. January (Month) 15 (Day) 1835 (Year)
7. AGE: 81 Yrs. 10 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): England
10. NAME OF FATHER: David Reeder
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Lydia
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Margaret Jones
(Address) Malad
15. Filed 11/20 1916 S. C. Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 18 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1916, to Nov 18 1916, that I last saw her alive on Nov 17 1916, and that death occured on the date stated above, at 9.15 A.M.
The CAUSE OF DEATH* was as follows:
Fracture femur.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Malnutrition
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) S. C. Ray M. D.
11/20 1916 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho. DATE OF BURIAL: Nov. 21 1916
20. UNDERTAKER: John McRichards ADDRESS: Malad, Ida

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16521

Registered No. 48

1. PLACE OF DEATH.

County of Lincoln

City of Hailbrook

Registration District No. 26

Primary Registration District No. 2071

(No. ..... , ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leo B. Peck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 20 (Day) 1905 (Year)

7. AGE: 11 Yrs. 3 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Leo Peck

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Addie Benson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leo Peck

(Address) Hailbrook Idaho

15. Filed 11/20 1916 T. Ray Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at 8:30 a. M.

The CAUSE OF DEATH* was as follows:

Accidental was crushed by a runaway team

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jas. F. Harrison Coroner M. D.

11/20 19 16 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailbrook Idaho — DATE OF BURIAL: Nov. 20 1916

20. UNDERTAKER: John McRichards — ADDRESS: Malad Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16522

Registered No. 49

1. PLACE OF DEATH.

County of Oneida

City of Malad

(No. ....., ... St.)

Registration District No. 26

Primary Registration District No. 2069

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha A. Allred

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept. (Month) 8 (Day) 1844 (Year)

7. AGE: 72 Yrs. 2 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Malad, Idaho

10. NAME OF FATHER: Porley M. Richards

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Martha Williams

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl A. Allred

(Address) Malad, Idaho.

15. Filed 11-26 1917 L. E. Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 24 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21 1916, to Nov 23 1916, that I last saw h[illegible] alive on Nov 23 1916, and that death occured on the date stated above, at 3:25 a M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) 1 Yrs. 4 mos. ds.

Contributory (Secondary) Organic heart disease

(Duration) several years yrs. mos. ds.

(Signed) [illegible] M. D.

Nov 27 1916 (Address) Malad, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad, Idaho — DATE OF BURIAL: Nov. 27 1916

20. UNDERTAKER: John M. Richards — ADDRESS: Malad, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2069
(No. ..... St.)

File No. 16523
Registered No. 58

1. PLACE OF DEATH.
County of Cassia
City of Malad
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. March 1 (Month) (Day) 1916 (Year)
7. AGE: Yrs. 7 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Malad, Idaho
10. NAME OF FATHER: Emmett Thomas
11. BIRTHPLACE OF FATHER (State or Country): Tennessee
12. MAIDEN NAME OF MOTHER: Martha Jones
13. BIRTHPLACE OF MOTHER (State or Country): Malad, Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emmett Thomas
(Address) Malad
15. Filed 11-30 1916 D Hay Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1916, to Nov. 1 1916, that I last saw h[illegible] alive on Nov 1 1916 and that death occured on the date stated above, at 4:30 a M.

The CAUSE OF DEATH* was as follows:

Marasmus.

(Duration) Yrs. 7 mos. 29 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) J M Richards M. D.

12/3 1916 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: Dec 2 1916

20. UNDERTAKER: Jno M Richards — ADDRESS: Malad Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16524

Registered No. 48

1. PLACE OF DEATH.

County of Oneida

City of Malad

Registration District No. 76

Primary Registration District No. 7069

(No. ..... , ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wallace Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 27 (Day) 1899 (Year)

7. AGE: 16 Yrs. 11 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Burnett Smith

11. BIRTHPLACE OF FATHER (State or Country): Logan Utah

12. MAIDEN NAME OF MOTHER: Mary Woogley

13. BIRTHPLACE OF MOTHER (State or Country): California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Smith

(Address) Malad R.F.D.

15. Filed 10-26 1916

D C Kay
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1916, to Oct 1916, that I last saw him alive on 23rd Oct 1916, and that death occured on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Kay, M. D.

10-26 1916 (Address) Malad City Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. Johns Ida — DATE OF BURIAL: 10-27 1916

20. UNDERTAKER: J M Richard — ADDRESS: Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNE - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16525

Registered No. 47

Registration District No. 26

Primary Registration District No. 3064

1. PLACE OF DEATH.

County of Oneida

City of Malad

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wallace Alvin Burns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 24 1916 (Month) (Day) (Year)

7. AGE: Yrs. 0 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... —

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Salt Lake City Utah

10. NAME OF FATHER Alvin J. Burns

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Florence Beck

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alvin L. Burns

(Address) Malad, Idaho.

15. Filed Oct 23 1916 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-22 1916, to 10-23 1916, that I last saw him alive on 10-23 1916, and that death occured on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Bronchitis.

(Duration) Yrs. 6 mos. = ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Kerns M. D.

10/23 1916 (Address) Malad Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: Oct 25 1916

20. UNDERTAKER: John M. Richards — ADDRESS: Malad Idaho

SYMS-YORK CO., PTRS. & BOOK. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16526

Registered No. 41

1. PLACE OF DEATH.

County of Oneida

City of Malad

(No. ....., ... St.)

Registration District No. 16

Primary Registration District No. 369

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Cock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 6 (Day) 1847 (Year)

7. AGE: 69 Yrs. 5 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Joseph Whitehead

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Ann Gotheth

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Cock

(Address) Malad

15. Filed Oct 19 1916

L. Ray
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1916, to Oct 1916, that I last saw her alive on Oct 15 1916, and that death occured on the date stated above, at 9-40 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs ..... mos. ..... ds.

(Signed) L. Ray M. D.

10-21 1916 (Address) Malad City Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad, Idaho — DATE OF BURIAL: Oct. 22 1916

20. UNDERTAKER: John M. Richards — ADDRESS: Malad, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 16527
Registered No. 40

1. PLACE OF DEATH.

County of Oneida
City of Malad

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Roberts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. April (Month) 28 (Day) 1851 (Year)

7. AGE: 65 Yrs. 5 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: David Davis

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Mary Jones

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Griffith T. Roberts
(Address) Malad, Idaho

15.
Filed 10-19 1916
D C Roy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1916, to Oct. 1916,
that I last saw her alive on Oct 17 1916,
and that death occured on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH* was as follows:
Gastric Carcinoma

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Chronic Bronchitis
(Duration) yrs. 6 mos. ds.

(Signed) D C Roy M. D.
10-19 1916 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad, Idaho — DATE OF BURIAL: Oct. 20 1916

20. UNDERTAKER: J. M. Richards — ADDRESS: Malad, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. [redacted] [redacted]TE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 16528
Registered No. 39

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mariann Christensen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. (Month) 14 (Day) 1908 (Year)

7. AGE: 8 Yrs. 8 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... at home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Newton, Utah

10. NAME OF FATHER Moses Christensen

11. BIRTHPLACE OF FATHER (State or Country) Newton, Utah

12. MAIDEN NAME OF MOTHER Mary Ann Cooley

13. BIRTHPLACE OF MOTHER (State or Country) Salt Lake City, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Moses Christensen
(Address) Malad Idaho

15. Filed 10-17 1916 D C Ray Local Registrar

SYMS - YORK CO., PTRS. & BKBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1916, to Oct 16 1916, that I last saw her alive on Oct 10 1916, and that death occured on the date stated above, at 12:06 P.M.

The CAUSE OF DEATH* was as follows:

Diabetis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Alton M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Newton, Utah — DATE OF BURIAL: Oct. 18 1916

20. UNDERTAKER: John M. Richards — ADDRESS: Malad, Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 26

Primary Registration District No. 2069

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16529

Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Oneida

City of Malad

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hugh Floyd Ezell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Sept. (Day) 12 1895

7. AGE: 21 Yrs. 1 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Malad, Idaho.

10. NAME OF FATHER: N. N. Ezell

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Martha E Jones

13. BIRTHPLACE OF MOTHER (State or Country): Malad, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Ezell

(Address) Malad, Idaho.

15. Filed 10-12 1916 — Ray, Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) — 11 (Day) — 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-9 1916, to 10-11 1916, that I last saw him alive on 10-11 1916, and that death occured on the date stated above, at 11:00 M.

The CAUSE OF DEATH* was as follows:

Tuberculosis.

(Duration) 4 Yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

10/17/1916 (Signed) J. M. Kerns M. D.

(Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: Sept. 13 1916

20. UNDERTAKER: J. M. Pickard — ADDRESS: Malad Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
(No. ..... St.)

File No. 16530
Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Oneida
City of Malad

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret W Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
July (Month) 6 (Day) 875 (Year)

7. AGE
41 Yrs. 2 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Malad Idaho.

10. NAME OF FATHER: Henry R. Evans

11. BIRTHPLACE OF FATHER
(State or Country) Wales

12. MAIDEN NAME OF MOTHER: Margaret Williams

13. BIRTHPLACE OF MOTHER
(State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W W Jones
(Address) Malad Ida.

15.
Filed Oct 2nd 1916
Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1916 to Oct 1 1916, that I last saw h[illegible] alive on [illegible] and that death occured on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:
Apoplexy,
(Duration) ..... Yrs. ..... mos. Instant ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J M Nevin M. D.
10/1 1916 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Ida — DATE OF BURIAL: Oct 3 1916

20. UNDERTAKER: J M Richards — ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 16531
Registered No. 36

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Daniels Jones
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: WL
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Sept (Month) 29 (Day) 1 96 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many 3 hrs. or 30 mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Walter Jones

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Stella Daniels

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Jones
(Address)

15. Filed Sept 30 1916 D C Kay Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29 1916 to Sept 29 1916 that I last saw h alive on Sept 29 1916 and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Kay M. D.
9-29-1916 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad
DATE OF BURIAL: Oct 1 1916

20. UNDERTAKER: Munn
ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 16532
Registered No. 3

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reynold Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. August 28 (Month) (Day) 1903 (Year)

7. AGE: 13 Yrs. ..... Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Malad Idaho

10. NAME OF FATHER: Wm H. Thomas

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Annie E. Reynolds

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W H Thomas Jr
(Address) Amer. Falls Ida

15. Filed Sept 25 1916
D C Ray
Local Registrar

SYMS - YORK CO., PTRS. & BKBS. 24852

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23 1916, to ..... 191..., that I last saw him alive on Sept 23 1916, and that death occured on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:
Accidental death by rope falling on Internal Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.
9/23 1916 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho
DATE OF BURIAL: Sept 24 1916

20. UNDERTAKER: John M. Richards
ADDRESS: Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 76
Primary Registration District No. 2069
(No. ..... St.)

File No. 16533
Registered No. 24
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stillborn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Sept (Month) 23 (Day) 1916 (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 5 mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Malad Idaho

10. NAME OF FATHER Calhoun Hughes

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Sarah Thorpe

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Malad Idaho

15. Filed 9/25 1916 J. Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Sept (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23 1916, to Sept 23 1916, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Ray M. D.
9/25 1916 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Samaria	9-25 1916

20. UNDERTAKER	ADDRESS
None	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

Primary Registration District No. 2069

File No. 16534

County of Oneida

City of St. John (No. ....., ... St.)

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joy C. Nielson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 1 (Day) 1916 (Year)

7. AGE: ....Yrs. 4 Mos. 20 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) St. John, Idaho.

10. NAME OF FATHER James D. Nielson

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Catherine Pierce

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. D. Nielson

(Address) .....

15. Filed Sept 21 1916 — D C Ray — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1916, to Sept 20 1916, that I last saw h[illegible] alive on Sept 20 1916, and that death occured on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:

pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.

9/21 1916 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. John Idaho — DATE OF BURIAL: Sept. 21 1916

20. UNDERTAKER: John M. Richards — ADDRESS: Malad, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 26

Primary Registration District No. 20604

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16536

Registered No. 20

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Oneida

City of Malad

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria Sanderson

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 15 (Day) 1849 (Year)

7. AGE: 67 Yrs. 1 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: James Arbon

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Susan

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Sanderson

(Address) Malad Idaho.

15. Filed 7-19 1916 D C Rey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 1916, to July 17 1916, that I last saw her alive on July 17 1916, and that death occured on the date stated above, at 10.30a M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(Duration) Yrs. 1 mos. 20 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D C Rey M. D.

7-19 1916 (Address) Malad City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: July 20 1916

20. UNDERTAKER: John M. Richards — ADDRESS: Malad Idaho

BYRNE - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16537

Registered No. 29

1. PLACE OF DEATH.

County of Oneida

City of Malad

(No. ....., ... St.)

Registration District No. 76

Primary Registration District No. 2069

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John D. Price

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 16 (Day) 1916 (Year)

7. AGE ....Yrs....Mos....ds. IF LESS than 1 day how many....hrs. or 10...min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malad

10. NAME OF FATHER: Josiah Price

11. BIRTHPLACE OF FATHER (State or Country): Malad, Idaho

12. MAIDEN NAME OF MOTHER: Sarah Beatrice Jones

13. BIRTHPLACE OF MOTHER (State or Country): Washakie Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josiah Price

(Address) Malad Idaho

15. Filed July 17 1916

D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....1916...., to ....1916....,
that I last saw h....alive on ....1916....,
and that death occured on the date stated above, at 9 a. M.
The CAUSE OF DEATH* was as follows:

No Physician in Attendance

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

....(Duration ....yrs. ....mos. ....ds.

1/16/16 (Signed) Premature Birth M. D.

(Address) Sarah A. McAllister

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?.....Malad City Idaho

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho. DATE OF BURIAL: July 16 1916

20. UNDERTAKER: John M. Pickard ADDRESS: Malad Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 16538
Registered No. 28

1. PLACE OF DEATH.
County of Oneida
City of Samaria
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Morse

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Oct. (Month) 22 (Day) 1848 (Year)

7. AGE: 66 Yrs. 8 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: John Morse

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Ann Bennett

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elmer Morse
(Address) Samaria Idaho

15. Filed 7-15 1916 D C Kay Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1915, to July 13 1916, that I last saw h[illegible] alive on 7-13 1916, and that death occured on the date stated above, at 12.25 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs ..... mos. ..... ds.

(Signed) D C Kay M. D.
7-15 1916 (Address) Malad City Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Samaria, Idaho
DATE OF BURIAL: July 17 1916

20. UNDERTAKER: John M Puckard
ADDRESS: Malad Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTPS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 16539
Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Oneida
City of Malad

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Evan Lewis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED. FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. October 21 1844 (Month) (Day) (Year)

7. AGE: 71 Yrs. 8 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Shepherd and
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Wales

10. NAME OF FATHER Thomas R. Lewis

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER Margaret Jones

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gladys M. Reese.
(Address) Malad City Idaho

15. Filed July 5 1916 — D C Ray, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1915, to July 1916, that I last saw h[illegible] alive on July 2 1916, and that death occured on the date stated above, at 3.45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Uremia

(Duration) ..... yrs ..... mos. ..... ds.

(Signed) D C Ray M. D.

7-3 1916 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: July 5 1916

20. UNDERTAKER: John M. Richards — ADDRESS: Malad

SYMS - YORK CO., PTRS. & ENGR. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16540

Registered No. 37

Registration District No. 76

Primary Registration District No. 7071

1. PLACE OF DEATH.

County of Ada

City of Meridian

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel Chidester

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): unmarried

6. DATE OF BIRTH. Sept (Month) 28 (Day) 1903 (Year)

7. AGE: 12 Yrs. 11 Mos. 21 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Deweyville Utah

10. NAME OF FATHER Myron A Chidester

11. BIRTHPLACE OF FATHER (State or Country) Salt Lake Utah

12. MAIDEN NAME OF MOTHER Sarah Ann Jackson

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Myron A Chidester

(Address) Holbrook Idaho

15.

Filed Sept 21 1916

D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1916, to Sept 19 1916, that I last saw h alive on Sept 19 1916, and that death occured on the date stated above, at 3 0 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 1 Yrs. mos. 3 ds.

Contributory (Secondary) Chronic Pneumonia

(Duration) yrs. mos. ds.

(Signed) D K Gronna M. D.

9/19 1916 (Address) Meridian Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Holbrook, Idaho — DATE OF BURIAL: Sept 21 1916

20. UNDERTAKER: John M. Richards — ADDRESS: Malad, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BKRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 86

County of Washington Primary Registration District No. 2112

City of Weiser (No. ....., ... St.)

File No. 16541

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Sandford.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Nov. (Month) 19 (Day) 1838 (Year)

7. AGE: 78 Yrs. 9 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wood Dipper Retired
(b) General nature of industry, business, or establishment in which employed (or employer): C

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Mark Sandford

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Susanna Hart

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas. Johnston
(Address) Weiser, Idaho.

15. Filed Dec 22nd 1916 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1916, to Dec 11 1916, that I last saw h.im alive on Dec 11 1916, and that death occured on the date stated above, at 7P. M.

The CAUSE OF DEATH* was as follows: Arteriosclerosis, Prostatic Hypertrophy.

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Mitchell M. D.

12/22/1916 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Racine. Wis. DATE OF BURIAL: ..... 191.....

20. UNDERTAKER: Northam & McCann ADDRESS: Weiser, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24655

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 56
Primary Registration District No. 1010
File No. 16542
Registered No. 25

1. PLACE OF DEATH.
County of Washington
City of Weiser
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Henry Campbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Sept (Month) 10 (Day) 1834 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. S. McCampbell
(Address) Weiser Idaho

15.
Filed ..... 191..... Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8th (Month) December (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 24 1916, to Dec 8th 1916, that I last saw him alive on Dec 7 1916, and that death occured on the date stated above, at 7 a. M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James A Young M. D.
Dec 9, 1916 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos. 17 days. In the State .....yrs.....mos.....days
Where was disease contracted if not at place of death? —
Former or usual residence Weiser, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida. | DATE OF BURIAL: 12/9 1916

20. UNDERTAKER: Northam & McCann | ADDRESS: Weiser Ida.

STATE OF IDAHO — CERTIFICATE OF DEATH

STATE BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 56
Primary Registration District No. 1010
File No. 16543
Registered No. 27

City of Dreamfield (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amos F. Hirr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Aug. (Day) 6 (Year) 1850

7. AGE: 66 Yrs. 4 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: U.S. Field agent
(b) General nature of industry, business, or establishment in which employed (or employer): Dpt. Agr.

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Peter Hirr

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Rebecca Nye.

13. BIRTHPLACE OF MOTHER (State or Country): Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. I.A. Poteet
(Address) Dreamfield Idaho

15. Filed 12-28 1916
W.P. Hamilton
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Traumatism of Brain
Instantly Died in few minutes
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Accidental fall on ice
(Duration) ... yrs. ... mos. ... ds.
(Signed) C.R. Shirley M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: Dec 30 1916

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

Briggs

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16544

Registered No. 49

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1009
(No. [illegible] St.)

2. FULL NAME Briggs.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Not known

6. DATE OF BIRTH: 12 (Month) 2 (Day) ~~1846~~ (Year)

7. AGE: 67 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Laborer.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. P. Kaun
(Address) Lewiston

15.
Filed 1-10-1917 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/29/1916, to 12/2/1916 that I last saw him alive on 12/1/1916, and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) yrs. mos. 12 ds.
Contributory (Secondary) General debility
(Duration) yrs. mos. ds.

(Signed) F. P. Kaun M. D.
12/3/1916 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: 12/3/1916

20. UNDERTAKER: [illegible]
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1007
File No. 16545
Registered No. 46

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. ..... , ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander Burns Colon Bardwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. (Month) 10 (Day) 1910 (Year)

7. AGE: 5 Yrs. 11 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: Jesse Bardwell

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: May Ervin

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jesse Bardwell
(Address) Agatha Idaho

15. Filed 1-10-1917
L. J. Pampeau
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28th 1916, to Dec 2 1916, that I last saw him alive on Dec 2 1916, and that death occured on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Amyloid Disease of Liver.
(Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Wigle M. D.
Dec 2 1916 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Asotin Wash — DATE OF BURIAL: Dec 2 1916

20. UNDERTAKER: H. R. Merchant — ADDRESS: Asotin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 87
Primary Registration District No. 2154
(No. .... St.)

File No. 16546
Registered No. .....

1. PLACE OF DEATH.
County of Washington
City of Midvale

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Patterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. April 15 (Month) 1861 (Day) 1 (Year)

7. AGE 55 Yrs. 5 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House Work.
(b) General nature of industry, business, or establishment in which employed (or employer)..... for Husband.

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER A Vieth

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Emma Susan Vieth

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Albert Walker
(Address) Wilburus Ida.

15. Filed Oct 4 1916 W H Marshall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 2. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h— alive on — 191...,
and that death occured on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....
(Duration ... yrs. ... mos. ... ds.

(Signed) W H Marshall M. D.
19... (Address) Midvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wilburus	Oct 3 1916
20. UNDERTAKER H Williams	ADDRESS Midvale

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

PLACE OF DEATH

OREGON STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registered No. 16547

County of Canyon

Village of Near Greenleaf or City of

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information"]

No. ..... St.; ..... Ward

[If death occurred in a Hospital or Institution give its Name instead of street and number.]

FULL NAME Wm. Delbert Johns.

PERSONAL AND STATISTICAL PARTICULARS

SEX: M.	COLOR: W.
DATE OF BIRTH: Aug (Month) 17 (Day) 16 (Year)	
AGE: ..... years, 2 months, 13 days	
SINGLE, MARRIED, WIDOWED, OR DIVORCED: S	
BIRTHPLACE (State or Country): Ore.	
NAME OF FATHER: Ralph Johns.	
BIRTHPLACE OF FATHER (State or Country): Kansas.	
MAIDEN NAME OF MOTHER: Mary Edom	
BIRTHPLACE OF MOTHER (State or Country): Ida.	
OCCUPATION: Baby.	

THE ABOVE STATED PERSONAL PARTICULARS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

(Informant) .....

(Address) .....

Filed Nov 1 1916 D. N. Marshall Registrar.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct (Month) 30 (Day) 1916 (Year)

I HEREBY CERTIFY, That I attended deceased from Oct 26 1916, to Oct 30 1916; that I last saw him alive on Oct 30 1916, and that death occurred, on the date stated above, at 8 05 M. The CAUSE OF DEATH was as follows:

Gastro enteritis

(duration) 4 days

Contributory none.

(duration) ..... days

(Signed) Jacob P. Gruwell M. D.

Oct 31 1916 (Address) Ontario Ore

SPECIAL INFORMATION only for Hospitals, Institutions, Transients, or Recent Residents.

Former or Usual Residence ..... How long at Place of Death? ..... Days

Where was disease contracted if not at Place of Death? .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, that it may be properly classified. The "Special Information" for persons dying away from home should be given in every instance.

MARGIN RESERVED FOR BINDING—THIS IS A PERMANENT RECORD

WRITE PLAINLY WITH UNFADING INK

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 20
Primary Registration District No. 207
File No. 16548
Registered No. 517

1. PLACE OF DEATH.
County of [redacted]
City of Rathdrum (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Henry Hite

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June 20 (Month) 1910 (Day) 1 (Year)

7. AGE: 6 Yrs. 5 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Elmer Hite

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Nora Waddell

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Elmer Hite
(Address) .....

15. Filed Jan 10 1917 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 7. (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 21 1916, to Dec. 7. 1916, that I last saw h[redacted] alive on Dec. 7. 1916, and that death occured on the date stated above, at 2:00 P. M.

The CAUSE OF DEATH* was as follows:
Scarlet fever
.....
.....
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Typhoid fever
(Duration ..... yrs. ..... mos. 24 ds.
(Signed) Frank [illegible] M. D.
12/8/16 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rathdrum — DATE OF BURIAL: Dec 8 1916

20. UNDERTAKER: [illegible] Stone — ADDRESS: Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 20
Primary Registration District No. 2051
File No. 16549
Registered No. 176

1. PLACE OF DEATH.
County of Kootenai
City of Post Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. Male
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Nov (Month) 30 (5th AM) (Day) 1916 (Year)
7. AGE: — yrs. — mos. — ds. IF LESS than 1 day how many 18 hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: ~
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Rural Post-Falls, Ida.
10. NAME OF FATHER: Luther Glover
11. BIRTHPLACE OF FATHER (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: Hattie B. Bishop
13. BIRTHPLACE OF MOTHER (State or Country): Kentucky
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B.F. Campbell M.D.
(Address) Post-Falls, Ida.
15. Filed 1/10 1917 D.D. Brunner Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 1 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov. 30th 5 20 P.M. 1916, to Dec 1 - 9 a.m. 1916 that I last saw he alive on Dec 1, (9 a.m.) 1916 and that death occurred on the date stated above, at 11 a.M.
The CAUSE OF DEATH* was as follows:
Inanition due to Premature birth
(Duration) ~ yrs. ~ mos. ~ ds.
Contributory (Secondary) Premature birth
(Duration) ~ yrs. ~ mos. ~ ds.
(Signed) B.F. Campbell M. D.
Dec 1 1916. (Address) Post-Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant View
DATE OF BURIAL: Dec 2 1916
20. UNDERTAKER: None
ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
(No. .... St.)

File No. 16551
Registered No. 20

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Elmore
City of Mountain Home

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Ross Hering

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept 24 1916 (Month) (Day) (Year)

7. AGE ..... Yrs. 3 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER O. R. Hering

11. BIRTHPLACE OF FATHER (State or Country) Wis

12. MAIDEN NAME OF MOTHER Ethel Ross

13. BIRTHPLACE OF MOTHER (State or Country) Ontario Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O Hering
(Address) Mtn Home Ida

15. Filed Dec 25th 1916 B W Mathes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 25th 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 18th 1916, to Dec. 24th 1916, that I last saw him alive on Dec. 24th 1916, and that death occured on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) Yrs. 2 mos. ..... ds.

Contributory (Secondary) Bronchitis acute

(Duration ..... yrs. mos. 10 ds.

(Signed) B W Mathes M. D.

12/25 1916 (Address) Mtn Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home, Idaho
DATE OF BURIAL: Dec. 26th 1916

20. UNDERTAKER: J. M. Corwin
ADDRESS: Mountain Home

SYMS - YORK CO., PTRS. & RBRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 16552
Registered No. 19

1. PLACE OF DEATH.
County of Elmore
City of Mtn home
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hazel Ellen VanSchaick

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Sept (Month) 7 (Day) 1842 (Year)

7. AGE: 74 Yrs. 3 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Me

10. NAME OF FATHER: Jerry Riley

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Elizabeth Carr

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. M. Cowan
(Address) Mtn Home Idaho

15.
Filed 12/22 1916
B. O. Walker
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24953

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 20th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Goiter (exophthalmic)

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Cowan M. D.
12/22/1916. (Address) Mtn Home Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home — DATE OF BURIAL: 12/23 1916

20. UNDERTAKER: J. M. Cowan - Mtn Home, — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16553

Registered No. 57

Registration District No. 90

Primary Registration District No. 2108

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Clearwater

City of Orofino

2. FULL NAME John W Sullivan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. — (Month) — (Day) 1868 (Year)

7. AGE: 48 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Plumber
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boston, Mass

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A B Canton

(Address) Orofino Ida

15. Filed Dec 12 1916 J. M. Fairly Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept - 11 1916, to Dec - 11" 1916, that I last saw him alive on Dec - 10" 1916, and that death occured on the date stated above, at 1 a.m. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary): Insanity

(Duration) yrs. 2. mos. ds.

(Signed) John W Givens M. D.

Dec 12 1916 (Address) Orofino, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ? yrs 2 mos — days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? —

Former or usual residence N. I. Santanum

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene Removal — DATE OF BURIAL: Dec. 15 1916

20. UNDERTAKER: Gus Nelson — ADDRESS: Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2468
File No. 16554
Registered No. 58

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cora May Harland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced
6. DATE OF BIRTH. ? (Month) ? (Day) 1876 (Year)
7. AGE: 40 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Indiana
10. NAME OF FATHER: ?
11. BIRTHPLACE OF FATHER (State or Country): ?
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (State or Country): ?
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. B. Leyton
(Address) Orofino - Ind
15. Filed Jan 1 1917 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 11 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 11 1916, to Dec 11" 1916, that I last saw her alive on Dec 10" 1916, and that death occured on the date stated above, at 1.30 A.M.
The CAUSE OF DEATH* was as follows:
Epilepsy.
(Duration) Yrs. 1 mos. 1 ds.
Contributory (Secondary): Insanity
(Duration) yrs. 1 mos. 1 ds.
(Signed) John W. Givens M. D.
Nov 11 1916 (Address) Orofino, Ida

*State the DISEASE CAUSING DEATH; or if deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs. 1 mos. 0 days. In the State ..yrs. ..mos. ..days
Where was disease contracted if not at place of death?
Former or usual residence N. D. Santanna

19. PLACE OF BURIAL OR REMOVAL: Pleasant Grove — DATE OF BURIAL: 12/13 1916
20. UNDERTAKER: W. A. Shaver — ADDRESS: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BORS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16555

1. PLACE OF DEATH. — Registration District No. 90
County of Clearwater — Primary Registration District No. 2168
City of Weippe — (No. ....., ... St.)
Registered No. 159

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Job Bonner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH May (Month) 22 (Day) 1858 (Year)

7. AGE 58 yrs. 6 mos. 23 ds. — IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) West Virginia

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. C. Snyder
(Address) Weippe Ida.

15.
Filed Jan 1 1917 — J. M. Gaines, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1915, to Dec 1916 that I last saw h alive on Oct 1916 and that death occurred on the date stated above, at 4½ A.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Lung & Vertebral Column
Pot Arteriosclerosis
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Carl Thompson M. D.
Dec 15 1916 (Address) Orofino

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Weippe	Dec 16 1916

20. UNDERTAKER	ADDRESS
M. E. Stoddard	Orofino Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 16556
Registered No. 62

1. PLACE OF DEATH.
County of Clearwater
City of Orofino (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John Duncan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH ..... 1 ..... (Month) (Day) (Year)

7. AGE ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) .....

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (State or Country) .....

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Jany 1 1917 J. M. Faist Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 12/18 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1916, to Dec 18 1916
that I last saw him alive on Dec 18 1916
and that death occurred on the date stated above, at 6 30 P.M.

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle M Forrwalt M. D.
Dec 19 1916 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida
DATE OF BURIAL: 12/19 1916

20. UNDERTAKER: W E Stoddard
ADDRESS: Orofino Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 2108
File No. 16557
Registered No. 61

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julian B. Mitchell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male.	White	married

6. DATE OF BIRTH
..... (Month) ..... (Day) 1875 (Year)

7. AGE
41 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Blacksmith
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Simms
(Address) Orofino. Idaho.

15.
Filed Jany 4 1917 J. M. Feney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
December (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7. 1916, to Dec 28 1916, that I last saw him alive on Dec. 28 1916, and that death occurred on the date stated above, at 4 1/10 M.

The CAUSE OF DEATH* was as follows:
General Paresis

..... (Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John W. Simms M. D.
Dec 28 1916 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 8 mos. 3 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? ?
Former or usual residence Idaho

19. PLACE OF BURIAL OR REMOVAL Cour d'Alene — DATE OF BURIAL ..... 191..

20. UNDERTAKER J. A. Goddard — ADDRESS Orofino

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16558

Registered No. 67

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2168
(No. ....., ... St.)

2. FULL NAME Oleus and H. Fillgeson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 1850
(Month) (Day) (Year)

7. AGE: 67 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): U.S.

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Johnnie Givens
(Address) Orofino. Idaho

15.
Filed Jany 1917 J M Fahy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec 31 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7. 1916., to Dec 31. 1916., that I last saw him alive on Dec 30. 1916, and that death occurred on the date stated above, at 12:00 M.

The CAUSE OF DEATH* was as follows:
Endocarditis

(Duration) 9 yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity.
(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Johnnie Givens M. D.
Dec 31 1916 (Address) Orofino. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 1 mos. 23 days. In the State 9 yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? Nez Perce Co. Idaho
Former or usual residence Idaho

19. PLACE OF BURIAL OR REMOVAL: Orofino — DATE OF BURIAL: Jany 2 1917

20. UNDERTAKER: H. C. Goddard — ADDRESS: Orofino

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
(No. ....., ... St.)
Registration District No. 12
Primary Registration District No. 2701
File No. 16559
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.
2. FULL NAME D. M. Davies

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 45 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wales

10. NAME OF FATHER no inf

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER no inf

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Davies
(Address) Kellogg, Idaho

15. Filed 12/20 1916 Geo. S. Parker Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 31 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1914, to Aug 31 1916, that I last saw h[illegible] alive on Aug 24 1916, and that death occured on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
"Miners Consumption"

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Alex D. McCracken M. D.
Sept 3 1916 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho — DATE OF BURIAL: Sept 3. 1916

20. UNDERTAKER: M. C. Chamberlin. — ADDRESS: Kellogg

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Hanbart
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 2201
(No. ....., ... St.)

File No. 2716560
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Matt Matteson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	Finn	widowed

6. DATE OF BIRTH: March 1 (Month) (Day) (Year)

7. AGE: 45 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Mats Matteson

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Sophia Macky

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Einar Matson
(Address) Emerine.

15. Filed 12/20 1916 Eva Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec 18 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1916, to ..... 191..., that I last saw h[illegible] alive on Dec 18 1916, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
accidental

.....(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. C. Lindsay M. D.
Dec 17 1916 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emerine Idaho — DATE OF BURIAL: Dec 20 1916

20. UNDERTAKER: M. C. Thornhill — ADDRESS: Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Grace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83.
Primary Registration District No. 2160
(No. ....., ... St.)

File No. 16561
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Millie Alice Packer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Female	White	Married (Write the word.)

6. DATE OF BIRTH
Nov. (Month) 12. (Day) 1916 (Year)

7. AGE
0 yrs. 1 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Grace, Idaho.

10. NAME OF FATHER Delbert M. Packer.

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Mabel Hatcher.

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. L. Evans
(Address) Preston R.F.D. 2 Idaho

15.
Filed Jan 3, 1917 J. H. Hubbard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Died suddenly without medical aid. — Never was sick 191..., that I last saw him ..., alive on — Never was sick 191..., and that death occurred on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:
Unknown, — Must probably Pneumonia

(Duration) 0 yrs. 0 mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Hubbard M. D.
19... (Address) Grace, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Riverdale Idaho.	Dec 29 1916.
20. UNDERTAKER	ADDRESS
X Drake Bros	Preston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Grace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83.
Primary Registration District No. 260.
(No. ....., St.)

File No. 16562
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mildred Alvira Packer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Nov (Month) 13 (Day) 1916. (Year)

7. AGE: 0 yrs. 1 mos. 16 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Grace, Idaho

10. NAME OF FATHER: Dilbert M. Packer.

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Mabel Walker.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D S Evans
(Address) Preston R. D. 2 Idaho

15. Filed Jan 3 1916 J. E. Hubbard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 28, (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1916, to Dec 28 1916, that I last saw her alive on Dec 27 1916, and that death occurred on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) — yrs. — mos. 2 ds.

Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) John Hubbard M. D.
19.... (Address) Grace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverdale, Idaho. DATE OF BURIAL: Dec 29, 1916

20. UNDERTAKER: X ADDRESS: Preston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 7133
File No. 16563
Registered No. 745

1. PLACE OF DEATH.
County of Boner
City of Sandpoint
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Conroyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1 (Year)

7. AGE
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER
(State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O J Gray
(Address) .....

15.
Filed Dec 28 1916 M McKinnon
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1916, to Dec 27 1916, that I last saw h[im] alive on Dec 26 1916, and that death occured on the date stated above, at 1 a M.

The CAUSE OF DEATH* was as follows:
Cancer of stomach
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O J Gray M. D.
19..... (Address) Sandpoint Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho — DATE OF BURIAL: Dec 30 1916

20. UNDERTAKER: C M Brown — ADDRESS: S P

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16564
Registered No. 944

Registration District No. 78
Primary Registration District No. 913 35

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Gallinger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH.
Nov (Month) 14 (Day) 1863 (Year)

7. AGE
53 Yrs. 1 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Oregon

10. NAME OF FATHER
John Cabble

11. BIRTHPLACE OF FATHER
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER
Cintha Dixon

13. BIRTHPLACE OF MOTHER
(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Gallinger
(Address) [illegible] Agate Lake

15.
Filed 20 Dec 23 1916 M McKinnon
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h.....alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pericarditis
Nephritis
Pernicious Anaemia
(Duration) 2 yrs. mos. ds.
Contributory (Secondary) [illegible]
(Duration) yrs. mos. ds.
(Signed) G N Jackson M. D.
Dec 23 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: Dec 24 1916

20. UNDERTAKER: E M Brower — ADDRESS: S P

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2165
File No. 16565
Registered No. 243

1. PLACE OF DEATH.
County of Boise
City of Lowman
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas Myers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1 (Year)

7. AGE
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER
(State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. J. Bray
(Address) .....

15.
Filed Dec 22 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1916, to Dec 21 1916, that I last saw h. alive on Dec 22 1916, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Cirrosis of the liver.

(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Alcoholism
(Duration) 3 yrs. ..... mos. ..... ds.
(Signed) O. J. Bray M. D.
19..... (Address) Hamilton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lone Grant	Dec 23 1916

20. UNDERTAKER	ADDRESS
E. M. Brown	Lo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonner — Registration District No. 18 — File No. 16566

City of Hope Ida — Primary Registration District No. 9153 — Registered No. 742

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Thomas Crawford Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 22 (Day) 1856 (Year)

7. AGE: 60 Yrs. 4 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: William Thomas Crawford

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Mary Reid

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Dec 19 1916 M McKinnon Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1916, to Dec 19 1916, that I last saw him alive on Dec 19 1916, and that death occured on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Houston E Snyder M. D.

Dec 19 1916 (Address) Hope Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hope Idaho — DATE OF BURIAL: Dec 19 1916

20. UNDERTAKER: Enochson — ADDRESS: Hope

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2135
File No. 16567
Registered No. 941

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W Lowery

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: mal
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH.
Apr (Month) 10 (Day) 1 (Year)

7. AGE
56 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)... —

9. BIRTHPLACE
(State or Country) Penn

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country) Penn

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Earnest Lowery
(Address) Sandpoint

15.
Filed Dec 18 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1916, to Dec 18 1916, that I last saw h[illegible] alive on Dec 18 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) [illegible]
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R N Jackson M. D.
Dec 19 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho — DATE OF BURIAL: Dec 19 1916

20. UNDERTAKER: C M Bowers — ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRUS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16568

Registered No. 940

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonner

City of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 2135

(No. ..... St.)

2. FULL NAME Lydia Merritt

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Apr (Month) 11 (Day) 1916 (Year)

7. AGE ..... Yrs. 8 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sandpoint

10. NAME OF FATHER Mark Merritt

11. BIRTHPLACE OF FATHER (State or Country) Maine

12. MAIDEN NAME OF MOTHER Arvella Allin

13. BIRTHPLACE OF MOTHER (State or Country) Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mark Merritt

(Address) Sandpoint Ida.

15. Filed 12 Dec 18 1916 M McKinnon Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from about Sept. 15th 1916, to Dec. 17th 1916, that I last saw h[er] alive on Dec. 17— 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E R Patterson M. D.

19.... (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: Dec 19 1916

20. UNDERTAKER: E M Brown — ADDRESS: S P

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 133
File No. 16569
Registered No. 992

1. PLACE OF DEATH.
County of Bonner
City of Laclede
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Halvor Halvorson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 6 (Day) 1864 (Year)

7. AGE: 52 Yrs. 8 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Talley Halvorson

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Christina Olsen Olsa

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. H. Halvorson
(Address) Laclede Idaho

15.
Filed Dec 19 1916 M McKinnon
Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Struck on head by log

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W M Knapp Coroner M. D.
19.... (Address) Hope Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Laclede — DATE OF BURIAL: Dec 21 1916

20. UNDERTAKER: C M Brown — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16571

Registered No. 937

1. PLACE OF DEATH.

Registration District No. 18 moore.

Primary Registration District No. 2135-

County of Bonner

City of Sandpoint (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME C. Wes Weaver.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 10 (Day) 1887 (Year)

7. AGE: 29 Yrs. 8 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Gardner -
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: C.S. Weaver

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Emma Carrell

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Weaver.
(Address) Sandpoint Ida.

15. Filed Dec 10 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-2 1916, to 12-6 1916, that I last saw h— alive on 12-6 1916, and that death occured on the date stated above, at 9:a M.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism following gun-shot wound -
(Duration) ..... Yrs. ..... mos. ½ ds.
Contributory (Secondary) Gun-shot wound left leg -
(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) Herrin D. Moore M. D.
11-9-1916 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida. DATE OF BURIAL: 12/17/1916

20. UNDERTAKER: E M Brown ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 18 Mrs.
Primary Registration District No. 2133.
File No. 16572
Registered No. 936

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Archie O'Donnell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 55 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Gardener
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. D. Payne
(Address) .....

15. Filed Dec 6 1916 M McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1916, to Dec 6 1916, that I last saw him alive on Dec 5 1916, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Cardiac Dilitation due Pneumonia

(Duration) 6 Yrs. ..... mos. ..... ds.
Contributory (Secondary): Grip
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Mary Kinnon M. D.
Dec 8 1916 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elmgrove | DATE OF BURIAL: Dec 7 1916

20. UNDERTAKER: O M Brown | ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS - YORK CO., PTRS. & STRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16579
Registered No. 9353

1. PLACE OF DEATH.

Registration District No. 78
Primary Registration District No. 2136

County of Bonner
City of Westmond Idaho, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza P Lanborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Feb (Month) 18 (Day) 1 (Year)

7. AGE: 53 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisc.

10. NAME OF FATHER: William Valois

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W D Lanborn

(Address) Cocolalla Ida

15.

Filed 10 Dec 2 1916 M McKinnon Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1916, to Dec 1 1916, that I last saw her alive on Nov 28 1916, and that death occured on the date stated above, at 2P. M.

The CAUSE OF DEATH* was as follows:

a Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R M Jackson M. D.

Dec 2 1916 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Westmond — DATE OF BURIAL: Dec 6 1916

20. UNDERTAKER: E M Brauner — ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2133

City of Clark Fork (No. ....., ... St.)

File No. 16575

Registered No. 237

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby White

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 17 (Day) 1916 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Compston White

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Josephine Burns

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15.

Filed Nov 17 1916 M McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17 1916, to Nov 17 1916, that I last saw h[illegible] alive on Nov 17 1916, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M McKinnon M. D.

Nov 8. 1916 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clark Fork

DATE OF BURIAL ..... 191...

20. UNDERTAKER: None

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1911

(No. Wallace Hospital St.)

File No. 16576

Registered No. 166

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Warren Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1 (Year)

7. AGE 83 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Miner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Not given

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wallace Hospital

(Address) Wallace Ida

15. Filed Dec 27 1916 T Leo Jundt Local Registrar

SYMS - YORK CO., PTRS. & SOMS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1916, to Dec 18 1916, that I last saw h— alive on Dec 18 10 a. m. 1916, and that death occured on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Cyanide

..... (Duration) 4 Yrs. — mos. — ds.

Contributory (Secondary) Coppery

..... (Duration — yrs. — mos. — ds.

(Signed) Chas. C. Dill M. D.

Dec 19 1916 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Ida	12/27 1916
20. UNDERTAKER	ADDRESS
C. C. Mallett	Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Idaho
(No. Providence Hospital)
Registration District No. 70
Primary Registration District No. 1011
File No. 16577
Registered No. 94

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dodor Sekrenich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	married

6. DATE OF BIRTH.
(Month) (Day) 1 (Year)

7. AGE
40 Yrs. ——— Mos. ——— ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Austria

10. NAME OF FATHER
unknown

11. BIRTHPLACE OF FATHER
(State or Country) Austria

12. MAIDEN NAME OF MOTHER
unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Marko Petijevich
(Address) Mullan Idaho

15.
Filed DEC 18 1916 191...
F Leo Dunphy
Local Registrar

SYMS - YORK CO., PTRS. & SDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1916, to Dec 16 1916, that I last saw him alive on Dec 16 1916, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration ... yrs. ... mos. ... ds.
(Signed) F Leo Dunphy M. D.
19... (Address)

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Butte	Dec 19 1916

20. UNDERTAKER	ADDRESS
Ward Und Co	Wallace Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10

Primary Registration District No. 1011

File No. 16578

County of Shoshone

City of Wallace (No. Wallace Hospital St.)

Registered No. 93

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dominico Galelo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 4 (Day) 1916 (Year)

7. AGE: 26 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Antonio Galetto

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. E. Ward

(Address) Wallace

15. Filed DEC 19 1916 191.....

F. Leo Trinder
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/14/16, 191.., to 12/15/16 191.., that I last saw h.. alive on 12/15/16 191.., and that death occured on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... ds.

(Signed) W. J. Smith M. D.

19..... (Address) Wallace

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2 days. In the State ..... yrs. ..... mos. 7 2/3 days

Where was disease contracted if not at place of death? Wallace Idaho

Former or usual residence Same "

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Dec 19 1916

20. UNDERTAKER: Hartung Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone — Registration District No. 70

City of Wallace — Primary Registration District No. 004

(No. Wallace Hospital) — File No. 16579

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eric Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH.

(Month) (Day) 1 (Year)

7. AGE

28 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... miner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Jno Matson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Mary Matson

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Hanson

(Address) Wallace Ida

15. Filed DEC 24 1916 191.....

F Leo Dunphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on 12/15/16 191...,

and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred C. Thum M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace	Dec 24 1916

20. UNDERTAKER	ADDRESS
Ward Mtg Co	Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

Primary Registration District No. 1011

File No. 16580

Registered No. 49

County of Shoshone

City of Wallace (No. Providence Hospital)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~50~~ ~~Fe~~

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 50 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. E. Ward

(Address) Wallace Ida

15. Filed Dec 15 1916 F Leo Lumley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1916, to Dec 17 1916, that I last saw him alive on Dec 17 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Accidental - Struck by a train

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F Leo Lumley M. D.

12/15 1916 (Address) .....

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Wallace Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: 12/15 1916

20. UNDERTAKER: Ward Hdw Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1054
File No. 16581
Registered No. 90

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur Wentworth Harpham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER Frank E Harpham

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Ada Wentworth

13. BIRTHPLACE OF MOTHER (State or Country) California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F E Harpham
(Address) Mace Ida

15. Filed Dec 6 1916 F Leo Turpin Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 5 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1916, to Dec 5 1916, that I last saw h.m alive on Dec 4 1916, and that death occured on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) La grippe
(Duration) Yrs. mos. 3-4 ds.

(Signed) Leo Mowry M. D.
12/5 1916 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Dec 6 1916

20. UNDERTAKER: Bruce G Boston — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16582

Registered No. 84

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 10

(No. Providence House St.)

2. FULL NAME Henry Billberg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 61 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Olaf Billberg

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pat. G. Cassidy

(Address) Mullan Idaho

15. Filed Dec 17 1916 F. Lis Jones Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 9 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1916, to Dec 9 1916, that I last saw h.. alive on Dec 9 1916, and that death occured on the date stated above, at 1030 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) H. Mowry M. D.

19 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mullan Ida — DATE OF BURIAL: 12/12 1916

20. UNDERTAKER: D. Worstell. — ADDRESS: Wallace

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 104

City of Wallace (No. Providence Hospital)

File No. 16583

Registered No. 188

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Carson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE 64 Yrs. ___ Mos. ___ ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer)... Gold Timber Mine

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER John Carson

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Jenny Thompson

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. E. Hard

(Address) Wallace Idaho

15. Filed Dec 9 1916 P Leo Quinn Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1916, to Dec 8 1916, that I last saw h alive on Dec 8 1916, and that death occured on the date stated above, at 5 P.M.

THE CAUSE OF DEATH* was as follows:

Fracture of Skull.

(Duration) ... Yrs. ... mos. 4 ds.

Contributory (Secondary) Encephalitis

(Duration) ... Yrs. ... mos. ... ds.

(Signed) D. C. Mowery M. D.

19 16 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL Mullan | DATE OF BURIAL Dec 10 1916

20. UNDERTAKER Ward Und Co | ADDRESS Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 64

Primary Registration District No. 2144

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16584

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Troy

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Reeder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. July (Month) 27 (Day) 1837 (Year)

7. AGE: 79 Yrs. 11 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: H. wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Frederick A. Plumb

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Catherine Smith

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lee H. Reeder

(Address) Moscow Ida

15. Filed Nov 28 1916 — J. M. Mccall, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1916, to Nov 27 1916, that I last saw her alive on Nov. 27 1916, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Oedema Lungs.

(Duration ..... yrs. ..... mos. 2 ds.

(Signed) J. M. Mccall M. D.

Nov 28 1916 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Ida — DATE OF BURIAL: Nov 29 1916

20. UNDERTAKER: Glen Price — ADDRESS: Moscow Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Troy
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 64
Primary Registration District No. 2144
(No. ....., ... St.)

File No. 16585
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME ..... Fildes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH. Nov (Month) 1 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..3.. hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... ✓
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Troy Ida.

10. NAME OF FATHER Jessie Fildes

11. BIRTHPLACE OF FATHER (State or Country) Troy Idaho.

12. MAIDEN NAME OF MOTHER Sarah Fildes

13. BIRTHPLACE OF MOTHER (State or Country) W. Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jesse Fildes
(Address) Troy Idaho

15. Filed Nov 2 1916 J. M. Carroll Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 2 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1. 1916, to Nov. 1 1916, that I last saw h.m alive on Nov 1 1916, and that death occured on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth
7 months

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Carroll M. D.
Nov 2 1916 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Moscow Ida. | DATE OF BURIAL Nov 2 1916

20. UNDERTAKER Jesse Fildes | ADDRESS Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 64
Primary Registration District No. 2144

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16586
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nels Olson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 25 (Day) 1843 (Year)

7. AGE: 73 Yrs. 3 Mos. 9 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: John Olson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Mrs Knutson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert Olson
(Address) Troy Ida

15. Filed Nov 3 1916 J. M. McCall Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 3 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1916, to Nov 3 1916, that I last saw h[illegible] alive on Oct 30 1916, and that death occured on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) J. M. McCall M. D.
Nov 3 1916 (Address) Troy Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Troy Creek
DATE OF BURIAL: Nov. 5 1916

20. UNDERTAKER: Albert Olson
ADDRESS: Troy Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 64

Primary Registration District No. 2144

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16587

Registered No. ____

1. PLACE OF DEATH.

County of Latah

City of Troy (No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martin Bowers Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: May 21 1844 (Month) (Day) (Year)

7. AGE: 72 yrs. 2 mos. 10 ds.

IF LESS than 1 day how many ..... *hrs.* or ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): Merchant Grocery Co. Troy

9. BIRTHPLACE (State or Country): Mercer County Ohio

10. NAME OF FATHER: Jesse Peterson

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sarah Ann Jones

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E H Field
(Address) Troy Ida

15. Filed July 15 1916 J. M. McCall Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1916, to July 15 1916, that I last saw him alive on July 15 1916, and that death occurred on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Chronic nephritis
and probable cardiac failure

(Duration) unknown yrs. — mos. ds.

Contributory (Secondary) Asthma Cardiac

(Duration) — yrs. 2 mos. ds.

(Signed) E H Field M. D.

July 17 1916 (Address) Troy Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 9 yrs. 10 mos. days. In the State 27 yrs. mos. days.

Where was disease contracted if not at place of death? Unknown

Former or usual residence Troy Ida

19. PLACE OF BURIAL OR REMOVAL: Moscow Cemetery — DATE OF BURIAL: July 16 1916

20. UNDERTAKER: J. N. Pickard — ADDRESS: Troy Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 64
Primary Registration District No. 2144
(No. .... St.)

File No. .....
Registered No. 16588
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank William Pumphrey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. 20 (Month) (Day) 1859 (Year)

7. AGE: 56 Yrs. 11 Mos. 25 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: William J. Pumphrey

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Sallie Ann

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. L. Carleton
(Address) Troy Idaho.

15. Filed Oct 27 1916
J. M. McCall
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 26 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1916, to Oct 26 1916, that I last saw him alive on Oct 26 1916, and that death occured on the date stated above, at 1.40 P. M.

The CAUSE OF DEATH* was as follows:

Arteris-Sclerosis

(Duration) unknown Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. McCall M. D.
Oct 27 1916 (Address) Troy Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Troy — DATE OF BURIAL: Oct 28 1916

20. UNDERTAKER: J. V. Prichard — ADDRESS: Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 16589
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Troy
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Inga Christena Holmes.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH. April 14 1853 (Month) (Day) (Year)

7. AGE: 63 Yrs. 7 Mos. 17 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: H. wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Nels Mongueuson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Johanna Swanson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) August Holmes
(Address) Troy Idaho

15. Filed Dec 6 1916 John McCall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 5 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1916, to Dec 5 1916, that I last saw her alive on Dec 5 1916, and that death occured on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis & Myocarditis
(Duration) 12 Yrs. mos. ds.
Contributory (Secondary) Dementia precox
(Duration 1 yrs. mos. - ds.
(Signed) John McCall M. D.
Dec 6 1916 (Address) Troy Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burnt Ridge Troy Ida — DATE OF BURIAL: Dec 7 1916

20. UNDERTAKER: J. Z. Pickard — ADDRESS: Troy Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM . S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 64

Primary Registration District No. 2144

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16590

Registered No. .....

1. PLACE OF DEATH.

County of Latah

City of, Troy

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Weeks Goodwin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH. March 4 1845 (Month) (Day) (Year)

7. AGE: 71 Yrs. 9 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Nova Scotia Canada

10. NAME OF FATHER James Weeks.

11. BIRTHPLACE OF FATHER (State or Country) England.

12. MAIDEN NAME OF MOTHER Jane Chapsel

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Marion Goodwin
(Address) Bovill Ida.

15. Filed Dec 5 1916 J. McCall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 4 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1916, to Dec 4 1916, that I last saw her alive on Dec 4 1916, and that death occured on the date stated above, at 2. P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. McCall M. D.

Dec 5 1916 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bethel Cemetary Troy Ida. DATE OF BURIAL: Dec 6 1916

20. UNDERTAKER: J. L. Packard ADDRESS: Troy Ida

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 16591
Registered No. ____

1. PLACE OF DEATH.
County of Latah
City of Troy
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mark B. Burfield
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May 4 (Month) 1872 (Day) (Year)

7. AGE: 44 Yrs. 7 Mos. 15 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Benjamin Burfield

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Constance Henshaw
(Address) Troy Idaho

15. Filed Dec 20 1916
J. Mumcaal
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 19 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1916, to Dec 19 1916, that I last saw him alive on Dec 19 1916, and that death occured on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Labar Pneumonia

(Duration) ____ Yrs. ____ mos. 10 ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) J. Mumcaal M. D.
Dec 1916 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Bethel. Troy Ida. DATE OF BURIAL: Dec 21 1916

20. UNDERTAKER: J. Z. Pickard ADDRESS: Troy Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 64
Primary Registration District No. 2144
(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16592
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Manuel Ellsworth Shoemaker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 1 (Day) 1916 (Year)

7. AGE: ..... Yrs. 6 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Troy Ida.

10. NAME OF FATHER: Scott Shoemaker

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Eva Dunbar

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Eva Shoemaker
(Address) Troy Ida

15. Filed Dec 3 1916 J. M. McCall Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20 1916, to Dec 2 1916, that I last saw him alive on Dec 1 1916, and that death occured on the date stated above, at 8.00 A.M.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary): Broncho-Pneumonia

(Duration ..... yrs. ..... mos. 5 ds.

(Signed) J. M. McCall M. D.

Dec 3 1916 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Brunt Ridge	Dec 3 1916
20. UNDERTAKER: J. E. Pickerd	ADDRESS: Troy Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 16593
Registered No. ____

1. PLACE OF DEATH.
County of Latah
City of Troy
(No. ____ ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Calvin Goodwin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec 8 (Month) (Day) 1916 (Year)

7. AGE: 75 Yrs. — Mos. — ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): New Brunswick
10. NAME OF FATHER: David Goodwin
11. BIRTHPLACE OF FATHER (State or Country): New Brunswick
12. MAIDEN NAME OF MOTHER: Eliza Chappel
13. BIRTHPLACE OF MOTHER (State or Country): New Brunswick

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Marion Goodwin
(Address) Benge Idaho

15. Filed Dec. 8 1916
J. M. McCall
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1916, to Dec 8 1916, that I last saw h— alive on Dec 8 1916, and that death occured on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) T.B.F. pneumonia

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) J. M. McCall M. D.
Dec 8 1916 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Bethel Cemetary Troy Ida
DATE OF BURIAL: Dec 9 1916

20. UNDERTAKER: J. Z. Packard
ADDRESS: Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

6V98 - YORK CO., PTRS. & BOBS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

16591

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6
Primary Registration District No. 2
(No. ....., ... St.)

File No. .....
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hilden Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 15 (Day) 1902 (Year)

7. AGE: 14 yrs. 9 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Carl Nelson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Ida Augusta Ekstrom

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Nelson
(Address) Troy Ida

15. Filed Sept 6 1916 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 5 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1916, to Sept 05 1916, that I last saw h[illegible] alive on Sept 4 1916, and that death occurred on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:
Spinal Cerebro
36 hours (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Valvular heart disease
Unknown (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E H Field M. D
9/5 1916 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burnt Bridge Troy Ida | DATE OF BURIAL: Sept 7 1916

20. UNDERTAKER: J. L. Pickard | ADDRESS: Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 4201
File No. 16595
Registered No. .....

2. FULL NAME Hamel Juntila

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. May (Month) 12 (Day) 1916 (Year)
7. AGE: ..... Yrs. 8 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Kellogg Idaho
10. NAME OF FATHER: Otto Juntila
11. BIRTHPLACE OF FATHER (State or Country): Finland
12. MAIDEN NAME OF MOTHER: Joke
13. BIRTHPLACE OF MOTHER (State or Country): Finland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Otto Juntila
(Address) Kellogg
15. Filed 12/20 1916 Geo. Pershe Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 2 1916 (Month) (Day) (Year)
Lindsay

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1916, to ..... 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Unknown

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. C. Lindsay M. D.
Dec 19 1916 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: Sept 3, 1916

20. UNDERTAKER: M. C. Trumbull. — ADDRESS: Kellogg

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

16597

Registration District No. 167
Primary Registration District No. 2196
(No. .... St.)

File No. .....
Registered No. 154

1. PLACE OF DEATH.
County of Cassia
City of Burley.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann McFate

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH.
May (Month) 1 (Day) 1859 (Year)

7. AGE
57 Yrs. 7 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Ireland.

10. NAME OF FATHER
Wood Lewis

11. BIRTHPLACE OF FATHER
(State or Country) Wales.

12. MAIDEN NAME OF MOTHER
Catherine Lewis

13. BIRTHPLACE OF MOTHER
(State or Country) Wales.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Nora Allen
(Address) Burley Ida.

15.
Filed Dec 13th 1917 Dr. J. C. Patterson
Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10 1916, to Dec 13th 1916, that I last saw her alive on Dec 13th 1916, and that death occured on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of stomach

(Duration) One yrs. mos. ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
12-13 1916 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: 12/15/ 1916

20. UNDERTAKER: L. L. Talloggy — ADDRESS: Burley Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 21 960
(No. ..... St.)

File No. 10508
Registered No. 155

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mabel Virginia Simonson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Single

6. DATE OF BIRTH.
Aug (Month) 17 (Day) 1916 (Year)

7. AGE
0 Yrs. 4 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9. BIRTHPLACE
(State or Country) Springdale Ida

10. NAME OF FATHER C A Simonson

11. BIRTHPLACE OF FATHER
(State or Country) Sweden

12. MAIDEN NAME OF MOTHER Selma E. Johnson

13. BIRTHPLACE OF MOTHER
(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C A Simonson
(Address) Springdale - Ida

15.
Filed Dec 31st 1917
Dr. J. C. Patterson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24652

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 31st (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 6 a. M.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia.
Dr. M. Din attendance, but all
symptoms were Broncho-Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. C. Patterson M. D.
1-1 1917 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pleasant Hill — DATE OF BURIAL Jan 3 1917

20. UNDERTAKER Rancratt — ADDRESS Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

File No. 16599

County of Idaho

Primary Registration District No. 2184

City of Kooskia (No. ....., ... St.)

Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Swan

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH

Not obtainable 1
(Month) (Day) (Year)

7. AGE about 83 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER (State or Country) Not obtainable

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. G. Rowton

(Address) Kooskia - Idaho

15.

Filed Dec 29 1916 J. M. Webber Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 29 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senility - Chronic Bronchitis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Webber M. D.

Dec 22 1916 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Turner (Private) Cemetery	Dec 28 1916
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
(No. ....., ... St.)

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16000
Registered No. 51

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pauline McGhee

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widdow

6. DATE OF BIRTH: April (Month) 2 (Day) 1852 (Year)

7. AGE: 64 yrs. 8 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Daniel Griffin

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Permelia Burson

13. BIRTHPLACE OF MOTHER (State or Country): Ills

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henrietta Hammond
(Address) Kooskia

15.
Filed Dec 29 1916
J M Verbeck Local Registrar
C. J. Johnson

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1916, to Dec 29 1916
that I last saw her alive on Dec 28 1916
and that death occurred on the date stated above, at 8 9 M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Verbeck M. D.
Dec 29 1916 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Walla Walla Wash
DATE OF BURIAL: 191

20. UNDERTAKER: C. J. Johnson
ADDRESS: Kamiah Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Sitis (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 106
Primary Registration District No. 2184

File No. 16601
Registered No. 56
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frederick Earnest Flynn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 27 (Day) 1913 (Year)

7. AGE: 3 yrs. — mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frederick Emery Flynn

11. BIRTHPLACE OF FATHER (State or Country): Ontario

12. MAIDEN NAME OF MOTHER: Lydia Mae Swonkeart

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frederick Emery Flynn
(Address) Sitis I

15.
Filed Dec 29 1916 J. Mitchell Chairs
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1916, to Dec 21 1916 that I last saw h[illegible] alive on Dec 21 1916 and that death occurred on the date stated above, at 6P M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H W Wentworth M. D.
Dec 21 1916 (Address) Sitis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: near Sitis
DATE OF BURIAL: Dec 23 1916

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16602
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5
Primary Registration District No. 2183
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mary Ellen Crea

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: May (Month) 18 (Day) 1894 (Year)
7. AGE: 22 yrs. 7 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, professsion, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: John W Crea
11. BIRTHPLACE OF FATHER (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Emma K Bowman
13. BIRTHPLACE OF MOTHER (State or Country): Virginia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Crea
(Address) Cottonwood Idaho
15.
Filed Dec 31 1916 H B Black Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1916, to Dec 31 1916 that I last saw her alive on Dec 31 1916, and that death occurred on the date stated above, at 8:30 P.M.
The CAUSE OF DEATH* was as follows:
Diabetes
Diabetic Coma
(Duration) 2 yrs. 6 mos. ds.
Contributory (Secondary) ~
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wesley F Orr M. D.
Dec 31 1917 (Address) Cottonwood Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Denver — DATE OF BURIAL: Jan 5 1917
20. UNDERTAKER: A A Penn — ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 18172

Form V. S. No. 5. 10M. 6-20-11.

CERT[redacted]E OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 23 16603

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 105

County of Idaho Primary Registration District No. 2183

City of Cottonwood (No. ....., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Jess

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: July (Month) 23 (Day) 1895 (Year)

7. AGE: 21 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *min.?*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Labor
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Henry Jess

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary Platt

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. H. Robertson

(Address) Cottonwood Ida

15.

Filed Dec 5th 1916 H Bowles
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 2 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29 1916 to Dec 2 1916 that I last saw him alive on Dec 1 1916, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

accident burn, caused by explosion of Gasoline

(Duration) — yrs. — mos. 3 ds.

Contributory (Secondary) Toxemia

(Duration) — yrs. — mos. — ds.

(Signed) G S Stockton M. D.

12/2 1916 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was Disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lenore

DATE OF BURIAL: Dec. 6 1916

20. UNDERTAKER: A. J. Maegg

ADDRESS: Grangeville Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 105
County of Idaho Primary Registration District No. 2103
City of Cottonwood (No. ....., ... St.)
File No. 241604
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Matilda Trautman
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1916 (Year)

7. AGE: ..... yrs. 2 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm Trautman

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Anna Haener

13. BIRTHPLACE OF MOTHER (State or Country): Kan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anton Haener
(Address) Ferdinand Ida

15.
Filed Dec 16 1916 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1916, to Dec 16 1916
that I last saw h~~e~~ alive on Dec 16 1916,
and that death occurred on the date stated above, at 10 A M.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. 1 mos. ..... ds.
(Signed) J D Shinnick M. D.
Dec 16 1916 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood — DATE OF BURIAL: Dec 18 1916

20. UNDERTAKER: A H Nave — ADDRESS: Cottonwood Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 16605
Registered No. 63

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alex. Heiner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Jan (Month) ..... (Day) 1914 (Year)

7. AGE: 2 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: David Heiner

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Myer

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John May
(Address) .....

15. Filed JAN 1 1917 191.... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1916, to Dec 31 1916, that I last saw him alive on Dec 29 1916, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Diphtheria
.....
.....
(Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) G. J. Parkinson M. D.
19.... (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar Ida
DATE OF BURIAL: 1/2 1917

20. UNDERTAKER: .....
ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 16606
Registered No. 82

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph Thornton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Should be carefully supplied. AGE should be stated EXACTLY. ERRORS in N. B.—Every item of information should be stated in plain terms, so that it may be properly classified. Error in statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Error in statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 1 (Day) 1916 (Year)

7. AGE: Yrs. 0 Mos. 2 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Rexburg Idaho

10. NAME OF FATHER E. N. Thornton

11. BIRTHPLACE OF FATHER (State or Country) America

12. MAIDEN NAME OF MOTHER Lottie Hawksworth

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. N. Thornton
(Address) Rexburg

15. Filed 12/28 1916 I. Gleske Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-18 1916, to 12-28 1916, that I last saw h— alive on 12-28 1916, and that death occured on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:
Erysipelas

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) I. Gleske M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg Ida — DATE OF BURIAL: 12/30 1916

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

BRAD - YORK CO., PTRS. & BRDS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 16607
Registered No. 81

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lynn R. Hamilton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH. Sept. (Month) 19 (Day) 1916 (Year)

7. AGE ..... Yrs. 3 Mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Baker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sugar City Idaho

10. NAME OF FATHER Robert Hamilton

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Elizabeth Gunderson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R L Hamilton
(Address) Sugar

15. Filed DEC 29 1916 191 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1916, to Dec 27 1916, that I last saw him alive on Dec 26 1916, and that death occured on the date stated above, at 3:20 a M.

The CAUSE OF DEATH* was as follows:
Bronchites

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Sharpe M. D.
Dec. 1916 (Address) Sugar City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sugar — DATE OF BURIAL 12/30 1916

20. UNDERTAKER Rigby — ADDRESS Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ..... , ... St.)

File No. 16608
Registered No. 80

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Madison
City of Rexburg

2. FULL NAME Elden B. Manwaring

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH.
Sept (Month) 30 (Day) 1916 (Year)

7. AGE
..... Yrs. 2 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Victor Manwaring

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Hortense Bird

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Victor Manwaring
(Address) Rexburg

15. DEC 28 1916
Filed ..... 191....
G. G. Gee
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
12 (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/26 1916, to 12-27 1916, that I last saw h— alive on 12/27 1916, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia
.....
.....
.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....
.....(Duration .....yrs.....mos.....ds.

(Signed) G. G. Gee M. D.
19..... (Address) .....

*State the DISEASES CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 12/29 1916

20. UNDERTAKER: John O. Phillips — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

DYMO - YORK CO., PTRS. & BKBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16609

Registered No. 79

1. PLACE OF DEATH.

Registration District No. 100

County of Canyon Creek Primary Registration District No. 2178

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anthon Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb (Month) 25 (Day) 1845 (Year)

7. AGE: 71 Yrs. 10 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Anthon Nelson

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Cornelia Harriman

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Harriman

(Address) Canyon Creek

15.

Filed 12-27 1916

Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Shell of rust stuck in windpipe

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr Taylor M. D.

19..... (Address) Rigby

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Creek — DATE OF BURIAL: 12/28 1916

20. UNDERTAKER: John Phillips — ADDRESS: Ferdinand

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 16610
Registered No. ....

1. PLACE OF DEATH.
County of Mad
City of Rex
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ann D. Ellsworth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. Aug (Month) 11 (Day) 1834 (Year)
7. AGE: 84 Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): America
10. NAME OF FATHER: Oliver H. Dudley
11. BIRTHPLACE OF FATHER (State or Country): America
12. MAIDEN NAME OF MOTHER: Mary Ann Robinson
13. BIRTHPLACE OF MOTHER (State or Country): America
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ace Ellsworth
(Address) Rexburg
15. Filed 12/17 191 6
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 16 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Found dead in bed
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... Yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Merran — DATE OF BURIAL: 12/18 1916
20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYUS - YORK CO., PTRS. & BOBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. .... St.)

File No. 16611
Registered No. 77

1. PLACE OF DEATH.
County of Madison
City of Sugar
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Dec (Month) 12 (Day) 1916 (Year)

7. AGE
— Yrs. — Mos. — ds.
IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baker
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salem Idaho

10. NAME OF FATHER: Thomas White

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Annabell - Hope

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas White
(Address) Salem

15. Filed 12/12 1916
G. H. Estep
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
12 (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 7a M.
The CAUSE OF DEATH* was as follows:

Premature

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. A. Stupe M. D.
19... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: 12/13 1916
20. UNDERTAKER: Rigby — ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 16612
Registered No. 71

1. PLACE OF DEATH.
County of Madison
City of Rexburg
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susan J. K. Hubbard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. June (Month) 8 (Day) 1836 (Year)
7. AGE: 80 Yrs. 6 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Widow
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): America
10. NAME OF FATHER: Oliver N. Dudley
11. BIRTHPLACE OF FATHER (State or Country): America
12. MAIDEN NAME OF MOTHER: Maryann Robinson
13. BIRTHPLACE OF MOTHER (State or Country): America
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. D. Hubbard
(Address) Butte Mont
15. Filed 12/10 1917
A. Gieske
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 9 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

No disease

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) none M. D.
.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ames — DATE OF BURIAL: 12/11 1916
20. UNDERTAKER: John Phillips — ADDRESS: Redmond

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MEDICAL RECORD FOR BINDING

STUB - YORK CO., PTRS. & STNRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 16613
Registered No. 75

1. PLACE OF DEATH.
County of Madison
City of Plant
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John L. Hunsley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 28 (Day) 1899 (Year)

7. AGE: 17 Yrs. 1 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John E. Hunsley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Wealthy M. Brown

13. BIRTHPLACE OF MOTHER (State or Country): Oxford Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John L. Hunsley
(Address) Plant

15.
Filed 12/9 1917
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 7 (Day) 16 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/6 1916, to 12/7 1916, that I last saw him alive on 12/7 1916, and that death occured on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. Warner M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Plano
DATE OF BURIAL: 12/11 1916

20. UNDERTAKER: J. Myers
ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNS - YORK CO., PTRS. & BOOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16614

Registered No. 52

Registration District No. 96

Primary Registration District No. 1009

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob L Clunder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Not known (Month) 1866 (Day) (Year)

7. AGE: 48 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F F Hamm

(Address) Lewiston

15. Filed 1-10- 1917 L J Perkins Local Registrar

SVMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/28/1916, to 12/30/1916, that I last saw h... alive on 12/30/1916, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows: Gun shot through brain

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) none

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F F Hamm M. D.

19..... (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos:.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: Dec 30 1916

20. UNDERTAKER: C. F. Vassar — ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16616

Registered No. 54

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. Boyd & Capitol st.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME L. L. Noyes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. (Month) (Day) (Year): —

7. AGE: 58 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. C. Cameron

(Address) Lewiston Idaho

15.

Filed 1-10-1917

L. J. Perkins
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 26th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21st 1916, to Dec 26th 1916, that I last saw h[illegible] alive on Dec 26th 1916, and that death occured on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Acidosis & Lungs following loss of [illegible]

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) D. C. Cameron M. D.

19..... (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: New Meadows — DATE OF BURIAL ..... 191..

20. UNDERTAKER: [illegible] — ADDRESS Lewiston

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 95
Primary Registration District No. 1009
File No. 16617
Registered No. 33

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. Idaho St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Mitchell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR, DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. — (Month) — (Day) 1 (Year)

7. AGE: 80 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Mitchell

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W A Mitchell
(Address) Idaho - Ida

15.
Filed 1-10- 1917
L J Perbeau
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
12 (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191—, to — 191—,
that I last saw h— alive on — 191—,
and that death occured on the date stated above, at 4.6 M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. Harvey Brown M. D.
19... (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 12/21 1916

20. UNDERTAKER: [illegible] — ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 9009
File No. 16618
Registered No. 52

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. White Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Miss Lous Chapman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.
December (Month) 28th (Day) 1850 (Year)

7. AGE
65 Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... County Treasurer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Wisconsin

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. Thatcher
(Address) Lewiston Idaho

15.
Filed 1-10-1917
L J Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1916, to Dec 18 1916, that I last saw h[illegible] alive on Dec 18 1916, and that death occured on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Gastric Hemorrhage
.....(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Ulcer of Pyloris
.....(Duration 3 yrs. ..... mos. 6 ds.
(Signed) Edwards Bedsock M. D.
Dec 19 1916. (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida. DATE OF BURIAL: 23 Dec 1916

20. UNDERTAKER: C J Vasen ADDRESS: Lewiston

SHOW STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOXS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9C
Primary Registration District No. 1009
File No. 16619
Registered No. 67

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 11th Ave & 19th St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gladen May McLean

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June 6 1917
(Month) (Day) (Year)

7. AGE: 6 Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J A McLean

11. BIRTHPLACE OF FATHER (State or Country): Ark

12. MAIDEN NAME OF MOTHER: Maud Fuller

13. BIRTHPLACE OF MOTHER (State or Country): Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J A McLean
(Address)

15. Filed 1-10- 1917
L J Perkins
Local Registrar

BYNS - YORK CO., PTRS. & BORS. 24852

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. 17 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1916, to Dec 17 1916, that I last saw her alive on Dec 17 1916, and that death occured on the date stated above, at 11 a. M.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) 1 Yrs. - mos. - ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) L J Perkins M. D.
12/17 1916 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Greer Idaho
DATE OF BURIAL ....191....

20. UNDERTAKER: C J Vasser
ADDRESS Lewiston

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 16620
Registered No. 50

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No.) Ranch 7 Mile East of Lewiston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lester Chas Gifford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Sept (Month) 6 (Day) 1893 (Year)
7. AGE: 73 Yrs. 3 Mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: Chas Lester Gifford
11. BIRTHPLACE OF FATHER (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Mary E Spangy
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C L Gifford
(Address)
15. Filed 1-10-1917 L. J Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ____ 191__ to ____ 191__, that I last saw h[illegible] alive on Dec 16 1916 and that death occured on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Gun shot injury - murdered
(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary)
(Duration ____ yrs. ____ mos. ____ ds.
(Signed) L J Perkins M. D.
12/18 1916 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL 191__
20. UNDERTAKER: C. J Vassar — ADDRESS: Lewiston

of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16622

Registered No.

1. PLACE OF DEATH.
County of Nez Perce
City of Nezperce (No. ....., ... St.)

Registration District No. .....
Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Watson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Mar 31 1829 (Month) (Day) (Year)

7. AGE: 87 yrs. 8 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Do

12. MAIDEN NAME OF MOTHER: Do

13. BIRTHPLACE OF MOTHER (State or Country): Do

14. THIS ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J M Hill
(Address) .....

15.
Filed ..... 191...
..... Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 12 4 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12 2 1916, to 12 4 1916 that I last saw him alive on 12 4 1916 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senile Debility

..... (Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E Taylor M. D.
12 7 1916 (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 47
Primary Registration District No. 2124
File No. 16623
Registered No. 14

1. PLACE OF DEATH.
County of Lewis
City of Nezperce
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 6 (Day) 1916 (Year)

7. AGE ... Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Inspect
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: O. H. Nesius

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Lilly Norris

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. O. H. Nesius
(Address) Nezperce, Idaho

15. Filed Oct 7 1916 J. F. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 7 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 6 1916, to Oct. 7 1916, that I last saw him alive on Oct. 7 1916, and that death occured on the date stated above, at 11 a. M.

The CAUSE OF DEATH* was as follows:
Patent foramen ovale

(Duration) - Yrs. - mos. - ds.

Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. F. Jones M. D.
9-7 1916 (Address) Nezperce, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ... 191...

20. UNDERTAKER | ADDRESS

SYMS - YORK CO., PTRS. & BOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 47
Primary Registration District No. 2124
File No. 16624
Registered No. 12

1. PLACE OF DEATH.
County of Lewis
City of Nez Perce
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leroy L. Hatalsing

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 27 (Day) 1892 (Year)

7. AGE: 24 Yrs. 7 Mos. 14 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: C. L. Hatalsing

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Minnie L. ——

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. L. L. Hatalsing
(Address) Nezperce, Idaho

15. Filed Oct. 11 1916
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 11 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 191..., to ~ 191...,
that I last saw h... alive on ~ 191...,
and that death occured on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:
Broken neck & cervical vertebra by fall - accident
Sudden death
(Duration) ~ Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Jones Coroner M. D.
10-11 1916 (Address) Nez Perce, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nezperce, Idaho — DATE OF BURIAL: 10-8 1916

20. UNDERTAKER: D. R. Donovan — ADDRESS: Nez Perce Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23

Primary Registration District No. 2107

File No. 16625

Registered No. 6

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Waddell.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH.

Dec (Month) 13 (Day) 1916 (Year)

7. AGE

..... Yrs. 3 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work... at Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho Falls Ida

10. NAME OF FATHER S. E. Waddell

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Maggie Biver

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. E. Waddell

(Address) Idaho Falls

15.

Filed Dec 1 191 7

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 17 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 191 6, to Dec 17 191 7, that I last saw h[illegible] alive on Dec 16 191 7, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Heart trouble Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. E. Fuller M. D.

19..... (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Idaho Falls Ida | DATE OF BURIAL 12/19 1916

20. UNDERTAKER E. E. Dunwoody | ADDRESS Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & ROBS. 24853

Dr Fuller

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16626

Registered No.

1. PLACE OF DEATH.
County of Gooding
City of (No. , St.)
Registration District No.
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rachel Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: 2 (Month) 28 (Day) 1861 (Year)

7. AGE: 55 yrs. 6 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Va

10. NAME OF FATHER: James Spence

11. BIRTHPLACE OF FATHER (State or Country): Va

12. MAIDEN NAME OF MOTHER: M Bice

13. BIRTHPLACE OF MOTHER (State or Country): Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W. D Wilson
(Address): Gooding Ida

15. Filed Sept 14th 1916 F.F. Cary M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 9 (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8th 1916, to Sept 14 1916, that I last saw her alive on Sept 14 1916, and that death occurred on the date stated above, at 8-30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 4 ds.

Contributory (Secondary): Influenza

(Duration) yrs. mos. 8 ds.

(Signed) H. C. Lamb M. D.
Sept 14 1916 (Address) Gooding, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding — DATE OF BURIAL: 9-16-1916

20. UNDERTAKER: A. E. Thompson — ADDRESS: Gooding Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PRTS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 16627
Registered No. 1

1. PLACE OF DEATH.
County of Jefferson
City of Mimis
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Hawke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M	White	Married (the word.)

6. DATE OF BIRTH
June 7 1864
(Month) (Day) (Year)

7. AGE
52 yrs. 6 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER William Hawke

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Ann Elmo

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. S. Merrill
(Address) Lenore RD #1

15.
Filed Feb 24 1917 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec 15 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1916, to Dec 15 1916, that I last saw him alive on Dec 15 1916, and that death occurred on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Milton M. D.
Dec 15 1916 (Address) Menan Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 75 ..... mos. ..... days. In the State 75 ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Annis — DATE OF BURIAL: Dec 17 1916

20. UNDERTAKER: J. K. Young — ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16628
Registered No. 7

1. PLACE OF DEATH.
County of Jefferson
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. ....., ... St.)

2. FULL NAME Inma Bryant

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 4 (Day) 1916 (Year)

7. AGE: ..... yrs. 3 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rigby RD 3

10. NAME OF FATHER: Albert Bryant

11. BIRTHPLACE OF FATHER (State or Country): Pearl Creek So Dakota

12. MAIDEN NAME OF MOTHER: Inma Barksdale

13. BIRTHPLACE OF MOTHER (State or Country): Coon Creek Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Bryant
(Address) RD 3 Rigby

15. Filed Feb 24 1917 Ray A Teske
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1916 to Dec 22 1916 that I last saw her alive on Nov 27 1916, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) Pneumonia Complica tion
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H Paxton M. D.
Dec 22 1916 (Address) Rigby

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? Same
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelton — DATE OF BURIAL: Dec 23 1916

20. UNDERTAKER: Veatch — ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 16629
Registered No. 3 45 Jan 10/17

1. PLACE OF DEATH.
County of Jefferson
City of Ta Belle
(No. ..... , ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Marie Lundquist
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Babe

6. DATE OF BIRTH: Dec. 21st 1916 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Babe
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Roy Lundquist

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: E. Marie Moses

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Frank Lundquist
(Address) Rigby - Ida

15. Filed Feb 24 1917 Ray H. Fuster. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec 28 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h alive on attendance 191...
and that death occurred on the date stated above, at 8:30a M.

The CAUSE OF DEATH* was as follows:

Premature
Atelectasis,

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray H. Fuster. M. D.
Dec 1916 (Address) Rigby - Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs. .....mos. ....days. In the State .....yrs. .....mos. .....days.
Where was disease contracted if not at place of death? same
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Little Butte Cem. DATE OF BURIAL: Dec 29 1916

20. UNDERTAKER: Friends. ADDRESS: Rigby Rt 3

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 7176
File No. 16630
Registered No. 4

1. PLACE OF DEATH.
County of Jefferson
City of St Maries (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah J. Lake

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Feb. (Month) 16 (Day) 1844 (Year)

7. AGE: 72 yrs. 10 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers widow
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Dayton O. Mo.

10. NAME OF FATHER: Richard Hill

11. BIRTHPLACE OF FATHER (State or Country): Don't Know.

12. MAIDEN NAME OF MOTHER: Rhoda Cowley

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Lake
(Address) Roberts Idaho Clay & Fisho

15. Filed Jan. 2 1917 J. F. Melton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) – 30 (Day) – 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15 1916, to Dec 24 1916, that I last saw her alive on Dec 24 1916 and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:
Hepatic Cirrhosis of Liver
6

(Duration) ..... yrs. 1 mos. ..... ds.
Contributory (Secondary) Pancreatitis
(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) J. F. Melton M. D.
Jan. 2 1917 (Address) St Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Butte Cemetery
DATE OF BURIAL: Jan 2 1917

20. UNDERTAKER: Mrs Geo Eames
ADDRESS: St Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17/48

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176

File No. 16631
Registered No. 5

1. PLACE OF DEATH.
County of Jefferson
City of Ryley (No. of , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eva Martell Ludlow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 1 (Day) 1893 (Year)

7. AGE: 23 yrs. 1 mo. mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spanish Fork Utah

10. NAME OF FATHER: Morris J Martell

11. BIRTHPLACE OF FATHER (State or Country): Spanish Fork Utah

12. MAIDEN NAME OF MOTHER: Mary G Riley

13. BIRTHPLACE OF MOTHER (State or Country): Spanish Fork Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L A. Ludlow
(Address) Lorenzo Idaho

15.
Filed Feb 24 1917 Ray A Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1916, to Dec 30 1916 that I last saw h[illegible] alive on Dec 30 1916, and that death occurred on the date stated above, at 9 6 M.

The CAUSE OF DEATH* was as follows:
Puerperal Eclampsia
Cerebral Hemorrhage
(Duration) yrs. mos. 5 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. D.
Dec 30 1916 (Address) H A Anderson Ryley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos. 5 days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spanish Fork Utah
DATE OF BURIAL: Jan 2 1916

20. UNDERTAKER: A. Hatch
ADDRESS: Ryley

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 10657

Registered No. 53

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 112, Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Louise Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 23d (Day) 1913 (Year)

7. AGE 3 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ada Co. Idaho

10. NAME OF FATHER Chas H. Miller

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Ethel Cole

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas H Miller

(Address) .....

15.

Filed ..... 191...

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 7th (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21st 1916, to Jan 7 1917, that I last saw h[illegible] alive on Jan 7 1917, and that death occured on the date stated above, at 2. P. M.

The CAUSE OF DEATH* was as follows:

Catarrh Jaundice

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

1/8 1917 (Signed) H. E. Smith M. D. (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL Dry Creek Cemetery DATE OF BURIAL 1/9 1917

20. UNDERTAKER Schmuck & Sederquist ADDRESS Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & BOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1016
File No. 16729
Registered No. 17

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eva Jane Wilson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: white
5. ~~SINGLE, MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.): child

6. DATE OF BIRTH: Sept 16 1915
(Month) (Day) (Year)

7. AGE: 1 yrs. 3 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shoshone Idaho

10. NAME OF FATHER: Jos. H. Wilson

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Pearl Todd

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jos. H. Wilson
(Address)

15. Filed Jany 10" 1917 J. L. Tuson Local Registrar

SYMS - YORK CO., PTRS. & SDRS. 19760

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. 9" TO 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 9 1917, to Jan 9 TO 1917, that I last saw h er alive on Jan 1 D 1917, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Acute Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.
Contributory (Secondary) Bronchial asthma
(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) C. D. Zeller M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone | DATE OF BURIAL: Jany 10' 1917

20. UNDERTAKER: O. J. Brandon | ADDRESS: Shoshone

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84
Primary Registration District No. 2161
(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16512
Registered No. 369

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William B. Bruneel

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S
6. DATE OF BIRTH. Dec. (Month) 2 (Day) 1916 (Year)
7. AGE ..... Yrs. ..... Mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Pocatello
10. NAME OF FATHER Byron C Bruneel
11. BIRTHPLACE OF FATHER (State or Country) Utah
12. MAIDEN NAME OF MOTHER Ethama Kunz
13. BIRTHPLACE OF MOTHER (State or Country) Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) 726 No 10th
15. Filed Dec 26 1916 O P Rees Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 24 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 1916, to Dec 24th 1916, that I last saw him alive on Dec 23rd 1916, and that death occured on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Umbilical Infection
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H A Coville M. D.
Dec 26 1916 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello — DATE OF BURIAL: Dec 26 1916
20. UNDERTAKER: Larkin & Sons — ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 5168
Registered No. 368

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Not Known (Month) 1 (Day) (Year)

7. AGE about 24 years. ....Yrs....Mos....ds.
IF LESS than 1 day how many....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. E. Johnson
(Address) Pocatello

15. Filed Dec 26 1916 O. B. Creely Local Registrar

BYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....1916...., to ....1916....,
that I last saw h....alive on ....1916....,
and that death occured on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:
Accidentally burned to death

....(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
....(Duration) ....yrs....mos....ds.
(Signed) J. A. Poole M. D.
Dec 16 1916 (Address) Corner Bannock Co

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Pocatello
DATE OF BURIAL: Dec. 16 1916

20. UNDERTAKER: Larkin & Sons
ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 16824

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ..., St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho

City of Whitebird

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Caroline Taylor

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1867 (Year)

7. AGE: 49 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Lewiston Ida

10. NAME OF FATHER: Samuel Benedict

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Isabelle Kelly

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank L Taylor

(Address) Whitebird Ida

15.

Filed ..... 191.....

W A Tackett
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1916, to Dec 1916, that I last saw her alive on Dec 20 1916, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

.....

.....

(Duration) 1 Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W A Tackett M. D.

Dec 27 1916 (Address) Whitebird

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Slate Creek

DATE OF BURIAL: Dec 27 1916

20. UNDERTAKER: Mandy

ADDRESS: Grangeville Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 48
Primary Registration District No. 2155
File No. 16957
Registered No. 933

1. PLACE OF DEATH.
County of Bonner
City of Hope
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jung Bing

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: Yellow
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 56 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Section hand R.R.

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. W. Gordon
(Address) Hope Idaho

15. Filed Mar 9 1917 M. M. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. 12 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Struck by train
Train killed instantly

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W M Knapp M. D.
19... (Address) Hope Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hope — DATE OF BURIAL: Feb 13 1917

20. UNDERTAKER: E. M. Brown — ADDRESS: Hope

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on Back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24654

17096

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [redacted]

Registered No. 7

1. PLACE OF DEATH.

County of Bonneville

City of Ida Falls

Registration District No. 13

Primary Registration District No. 2100

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orland Walker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH. Nov (Month) 6 (Day) 1916 (Year)

7. AGE 0 Yrs. 1 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Albert Walker

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Amy Lundberg

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cyrus Walker

(Address) Ida Falls, Ida

15. Filed Dec 1 1917

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

1 Pneumonia

Two Months Contraction

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

19..... (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Idaho Falls

DATE OF BURIAL 1/2 191[illegible]

20. UNDERTAKER [illegible] Dunwoody

ADDRESS Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

17098

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [redacted]

Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Ida Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2130

(No. ....., ... St.)

2. FULL NAME Geo. Tschikof

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 27 (Day) 1848 (Year)

7. AGE: 66 Yrs. 5 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Geo. Tschikof

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Mary Gallob

13. BIRTHPLACE OF MOTHER (State or Country): Austria.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Tschikof
(Address) Ida Falls, Ida

15. Filed Jan 1 191[illegible]

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31 (Day) 191[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-31-1917, to 12-31-1917, that I last saw h[illegible] alive on 12-31-1917, and that death occured on the date stated above, at [illegible] P.M.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

19..... (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 1/2 191[illegible]

20. UNDERTAKER: [illegible] Dunwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Dr Hollister

FORM V. S. No. 5-25 M. 1-16-13

17099

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [redacted]

Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2100

(No. ....., ..., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Nojeni

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Baby
(Write the word.)

6. DATE OF BIRTH. Dec 24 1916
(Month) (Day) (Year)

7. AGE 0 Yrs. 0 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho Falls

10. NAME OF FATHER M. Nojeni

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER K. Nojeni

13. BIRTHPLACE OF MOTHER (State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Nojeni

(Address) Idaho Falls

15.

Filed Jan 1 1917

Geo. Thurman
Local Registrar

SYMS - YORK CO., PTRS. & BKRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 27 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1916, to Dec 27 1916, that I last saw h[illegible] alive on Dec 27 1916 and that death occured on the date stated above, at 9a.M.

The CAUSE OF DEATH* was as follows:

Transposition Aurium
Delivery.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John O'Mellon M. D.

19..... (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Idaho Falls

DATE OF BURIAL 1/3/17 1917

20. UNDERTAKER E. E. Dennewoody

ADDRESS Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr Mellon

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 17164
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of St. Anthony
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josephine M. Philipson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	married

6. DATE OF BIRTH.
May (Month) 14 (Day) 1872 (Year)

7. AGE
44 Yrs. 5 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Ernest Unruh

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (State or Country) Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) T. P. Philipson
(Address) St. Anthony, Idaho

15.
Filed Nov 9 1916
W. A. Lord
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 8 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/6 1916, ~~to just one visit 191~~, that I last saw her alive on 11/6 1916, and that death occured on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:
Rheumatism + myocarditis

.....(Duration) Yrs. 2 mos. 4 ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Bowsher M. D.
11/9 1916 (Address) St. Anthony, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Anthony, Idaho — DATE OF BURIAL: Nov 9 1916

20. UNDERTAKER: Yager Bros. — ADDRESS: St Anthony, I.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 77

Primary Registration District No. 2176

File No. 17166

Registered No. .....

County of Teton

City of Felt

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gertrude Stalker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: May (Month) 14 (Day) 1916 (Year)

7. AGE: ..... yrs. 7 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Felt, Idaho

10. NAME OF FATHER: J. B. Stalker

11. BIRTHPLACE OF FATHER (State or Country): Ida.

12. MAIDEN NAME OF MOTHER: Hattie Fuller

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr J. B. Stalker

(Address) Felt Idaho

15.

Filed Jan 3 1917 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 15 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1916, to Dec 15 1916, that I last saw her alive on Dec 15 1916 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

19 .... (Address) Felt Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: [illegible] | DATE OF BURIAL: 12-16 1916

20. UNDERTAKER: ..... | ADDRESS: .....

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 17167
Registered No.

1. PLACE OF DEATH.
County of Teton
City of Driggs
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 77
Primary Registration District No. 2176

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Durtschi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Nov (Month) 23 (Day) 1916 (Year)

7. AGE
..... yrs. ..... mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Infant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Edward Durtschi

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Elizabeth Muchambury

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Durtschi
(Address) Driggs Ida.

15.
Filed Jan 3 1917 C Cherrington
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1916, to Dec 10 1916, that I last saw him alive on Dec 10 1916, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas F Martin M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 17174
Registered No. ____

1. PLACE OF DEATH
County of Bannock. Registration District No. 77
City of Pocatello (No. ____ St.) Primary Registration District No. 2156.
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wasemilen Chenier

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Dec (Month) 3 (Day) 1877 (Year)
7. AGE: 39 Yrs. ____ Mos. 29 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): ____
9. BIRTHPLACE (State or Country): Quebec Canada
10. NAME OF FATHER: Amelia Chenier
11. BIRTHPLACE OF FATHER (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Sofie Tarant
13. BIRTHPLACE OF MOTHER (State or Country): Canada
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. F. Lenier
(Address) 1300 Old Colony Chicago Ill.
15. Filed Jan 4- 1917. E. E. Fox Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 31 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1916, to Dec 31 1916, that I last saw h[is] alive on Dec 31 1916, and that death occured on the date stated above, at 11.9 M.
The CAUSE OF DEATH* was as follows:
Acute perforative appendicitis
(Duration) 4 Yrs. ____ mos. 3 ds.
Contributory (Secondary) Peritonitis
(Duration ____ yrs. ____ mos. 5 ds.
(Signed) L. L. G. Aucutt M. D.
12-31 1917 (Address) Bannock County Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bannock County Idaho — DATE OF BURIAL: 1/6 1917
20. UNDERTAKER: J. J. Mace — ADDRESS: Bannock County Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & STNR. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 79

Primary Registration District No. 215-6

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17176

Registered No. .....

1. PLACE OF DEATH.

County of Boundary

City of Bonners Ferry

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Harold Mullen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) 1 (Day) ..... (Year)

7. AGE: 36 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Chippewa, Wis

10. NAME OF FATHER: Matthew Mullen

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Jane Orje

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt Mullen

(Address) Moyie Ida

15. Filed 12/27/1917. E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 26 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h.. alive on Dec. 26 1916,

and that death occured on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Strychnine Poisoning (Suicidal)

(Duration) ..... Yrs. ..... mos. 30 minutes, ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

12/27/1917. (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: 1/2 1917

20. UNDERTAKER: J. T. Mann — ADDRESS: Bonners Ferry Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79.
Primary Registration District No. 215-6.
File No. 17177
Registered No.

1. PLACE OF DEATH.
County of Bonneville
City of Bonneville Ferry Idaho (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Monroe Owens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 81 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Worcester Mass

10. NAME OF FATHER: — —

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Della Bourcier

13. BIRTHPLACE OF MOTHER (State or Country): Petersburg Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo C Owens
(Address) Ferry Idaho

15. Filed 12/18/1916. E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1916, to Dec 16 1916, that I last saw h[im] alive on Dec 16 1916, and that death occured on the date stated above, at 12.5a M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction from
Carcinoma of Sigmoid
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) Pleurisy
(Duration — yrs. — mos. 6 ds.
(Signed) C. J. St. Amant M. D.
12-20 1917 (Address) Bonneville Ferry Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL, OR REMOVAL: Bonneville Ferry Idaho — DATE OF BURIAL: 12/18 1916

20. UNDERTAKER: Geo T Moore — ADDRESS: Bonneville Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79.
Primary Registration District No. 2156.
File No. 17178
Registered No. .....

1. PLACE OF DEATH.
County of Bonner
City of Bonners Ferry (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Lagore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE 48 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed 12/14/ 1916. E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 13th. 1916.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Dropped over dead - the Coroner, Dr. A. Reich investigated.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Bonners Ferry Idaho — DATE OF BURIAL 12/15 1916

20. UNDERTAKER Geo. T. Wade — ADDRESS Bonners Ferry Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [redacted]

Registered No. 17384

1. PLACE OF DEATH.

County of Fremont.

City of Parker

If death occurs away from usual residence, give facts called for under special information.

Registration District No.....

Primary Registration District No.....

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Franklin Poulton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug. (Month) 8 (Day) 1900 (Year)

7. AGE: 16 Yrs. 4 Mos. 20 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. E. Poulton

11. BIRTHPLACE OF FATHER (State or Country): Wyoming

12. MAIDEN NAME OF MOTHER: Emma V. Grover

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. E. Poulton
(Address) Parker, Idaho

15. Filed Dec 29 1916 W. W. Brent Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1916 to Dec 28 1916, that I last saw h... alive on Dec 28 1916, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
~~Bronchial Pneumonia~~
Gun Shot Wound

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Wright M. D.

19..... (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parker, Idaho — DATE OF BURIAL: Dec. 29 1916

20. UNDERTAKER: Wm D. Yager — ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Fremont

City of Parker

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

File No. .....

Registered No. 2992 1892

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward N. Hunter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 23 (Day) 1903 (Year)

7. AGE: 13 Yrs. 6 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At School

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm E. Hunter

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lillie M. Severe

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm E. Hunter

(Address) Parker, Idaho.

15. Filed Dec 26 1916 W Burt

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Not at all 191..., to ..... 191....., that I last saw h.....alive on ..... 191....., and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Frozen to Death

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs.....mos.....ds.

(Signed) W Burt M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parker, Ida. DATE OF BURIAL: Dec 28 1916

20. UNDERTAKER: Wm D. Yager ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17393

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of Parker

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Ann Wardle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 1 (Day) 1844 (Year)

7. AGE: 72 Yrs. 9 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Samuel Eegbert

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Maria Beckstead Bigelow

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph S. Wardle

(Address) St. Anthony -

15. Filed Dec 6 1916

W D Yager
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 6 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1916 to Dec 6 1916, that I last saw h. alive on Dec 6 1916, and that death occured on the date stated above, at 7:40 P.M.

The CAUSE OF DEATH* was as follows:

Lagrippe

.....(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary): Senility

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W D Yager M. D.

19..... (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the [redacted].....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parker - Idaho — DATE OF BURIAL: Dec. 10 1916

20. UNDERTAKER: W. D. Yager — ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17394

Registered No. .....

1. PLACE OF DEATH.

County of Fremont

City of St Anthony,

(No. Ida Ind Training School Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. .....

Primary Registration District No. .....

2. FULL NAME Mrs Martha Hartshorn,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov IIth 1894 (Month) (Day) (Year)

7. AGE: 22 Yrs. ..... Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER: Jacob Heer

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER: Martha

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B.J.Hortshorn,

(Address) St Anthony,

15. Filed Dec 8 1916 W B Wert Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: I2 (Month) 8 (Day) I6 (Year) 191

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1916, to I2-8-I6 191, that I last saw her alive on I2-8-I6 191, and that death occured on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) Volvulus

(Duration ..... yrs. ..... mos. 9 ds.

(Signed) J Mansfield M. D.

Dec 9 1916 (Address) St Anthony, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Junction City Kas. DATE OF BURIAL 191

20. UNDERTAKER: Wm.D.Yager, ADDRESS St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 17395
Registered No. .....

1. PLACE OF DEATH.
County of Fremont.
City of St Anthony.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. ....., ... St.)

2. FULL NAME Theron Birch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Nov. (Month) 27 (Day) 1916 (Year)

7. AGE
..... Yrs. ..... Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. R. Birch

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lizzie Layton

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. R. Birch.
(Address) St Anthony, Ida.

15. Filed Dec 26 1916 W D West Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 25 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1916, to Dec 25 1916, that I last saw h[illegible] alive on Dec 24 1916, and that death occured on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
Capilary Bronchitis
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J Morfeed M. D.
Dec 26 1916 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wilford
DATE OF BURIAL: Dec. 26 1916

20. UNDERTAKER: Wm D. Yager
ADDRESS: St. Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 99

Primary Registration District No. 2177

File No. 17396

County of Fremont

City of St Anthony (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bethia Barnes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Aug (Month) 11 (Day) 1860 (Year)

7. AGE: 56 yrs. 4 mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Berkshire England

10. NAME OF FATHER: Jno Wilkins

11. BIRTHPLACE OF FATHER (State or Country): Berkshire England

12. MAIDEN NAME OF MOTHER: Mary Woodward

13. BIRTHPLACE OF MOTHER (State or Country): Berkshire England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Packer
(Address) St Anthony, Ida.

15. Filed Dec 23 1916 W D Wert Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1916 to Dec 22 1916 that I last saw her alive on Dec 17 1916 and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Liver

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J Morfeld M. D.

12/22 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: 12/24 1916

20. UNDERTAKER: Yager Bros. — ADDRESS: St Anthony Ida

SYMS - YORK CO., PTRS. & BDRS. 19700

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17397

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oren F. Elliott

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Aug (Month) 16 (Day) 1862 ~~1866~~ (Year)

7. AGE: 54 Yrs. 4 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... day laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Geo. W. Elliott

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Tacy J. Lathbury

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs O. F. Elliott
(Address) St Anthony - Idaho

15. Filed Dec 23 1916 C. Dwyer Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 17 1916, to Dec 21 1916, that I last saw him alive on Dec 21 1916, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Hepatic abscess

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) none.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. C. Gray M. D.

12/22 1916 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Anthony — DATE OF BURIAL: Dec. 23 1916

20. UNDERTAKER: W. D. Yager — ADDRESS: St Anthony

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 17398
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of St Anthony
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ora Welland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Dec (Month) 17 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. 1½ ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) St Anthony Idaho

10. NAME OF FATHER Jno W Welland

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Gertrude Andrews

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) J W Welland

15. Filed Dec 19 1916 W D Wall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 19 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1916, to Dec 19 1916, that I last saw h[illegible] alive on Dec 18 1916 and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:
Patent foramen
.....
.....
.....(Duration) ..... Yrs. ..... mos. 1½ ds.
Contributory (Secondary) Premature birth
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) A Morrison M. D.
12/19 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Milford — DATE OF BURIAL Dec 20 1916

20. UNDERTAKER None — ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOBS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17399

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reinfred M. Chase

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH. Feb (Month) 14 (Day) 1913 (Year)

7. AGE 3 Yrs. 8 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Fremont Co. Idaho

10. NAME OF FATHER H E Chase.

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Blanch E Rule. Chase

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E M Chase

(Address) St Anthony.

15.

Filed Nov 14 1916

W D Weir
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/13 a.m. 1916, to 11/13 P.M. 1916, that I last saw her alive on 11/13 1916, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

I Leo-colitis

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) F M Boucher M. D.

11-15-1916 (Address) St. Anthony, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL St Anthony Idaho. **DATE OF BURIAL** Nov 15 1916

20. UNDERTAKER N D Yeager **ADDRESS** St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17400

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.

County of Fremont

City of Wilford

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William J. Cahoon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 3 (Day) 1882 (Year)

7. AGE: 34 Yrs. 4 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Rancher

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Rais Cahoon

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary Jarvis

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wm J. Cahoon

(Address) Wilford, Idaho

15. Filed Nov 30 1916

W H Wright
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 29 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1916, to Nov 29 1916, that I last saw him alive on Nov 28 1916, and that death occured on the date stated above, at 10a. M.

The CAUSE OF DEATH* was as follows:

Septicemia (Resulting from quack treatment, perforation of integument of entire body.

(Duration) about 10 Yrs. mos. 10 ds.

Contributory (Secondary) Chronic Interstitial nephritis

(Duration) yrs. mos. ds.

(Signed) A Monfat M. D.

11-30 1916 (Address) St Anthony Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilford, Idaho

DATE OF BURIAL: Dec. 1 1916

20. UNDERTAKER: Wm D. Yager

ADDRESS: St Anthony

V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 17401
Registered No. .....

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Fremont
City of St Anthony

2. FULL NAME Verna Rose

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	single

6. DATE OF BIRTH.
Nov. (Month) 30 (Day) 1916 (Year)

7. AGE
X Yrs. X Mos. X ds.
IF LESS than 1 day how many ..... hrs. or 45 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Moore Rose

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Eliza Terran

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Moore Rose
(Address) St Anthony

15.
Filed Dec 1 1916 W Burk
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1916, to Nov 30 1916, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Premature delivery at 6½ mos
45 Min

.....(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A Merrifield M. D.
12/1/1916 (Address) St Anthony Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Chester — DATE OF BURIAL: Dec. 1 1916

20. UNDERTAKER: Wm D. Yager — ADDRESS: St Anthony.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 17402
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of ashton
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME mrs annie coleman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH.
6 (Month) 15 (Day) 1866 (Year)

7. AGE
50 Yrs. 5 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Owen Jones

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Bowen

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. Burchamy
(Address) St Anthony

15. Filed NOV 18 1916 W. Bowcutt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
11 (Month) 18 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/26 1916, to Nov 18 1916, that I last saw h[illegible] alive on 5/26 1916 and that death occured on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:
Cardiac arthma
(Duration) 1 Yrs. — mos. 14 ds.
Contributory (Secondary) arthritis deformans
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Burchamy M. D.
11/18 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ora Dale — DATE OF BURIAL: Nov 20 1916

20. UNDERTAKER: None — ADDRESS: —

[illegible] Co., Prtrs. & Bndrs. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17403

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. Wilford, Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of St Anthony

2. FULL NAME William Preston Chantrell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 18 (Day) 1916 (Year)

7. AGE ..... Yrs. 9 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wm Chantrell

11. BIRTHPLACE OF FATHER (State or Country) Cottage Utah

12. MAIDEN NAME OF MOTHER Susie Martineau

13. BIRTHPLACE OF MOTHER (State or Country) Logan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) W M Chantrell Wilford Idaho

15. Filed Nov 19, 1916 W Dewitt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 19 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16 1916, to Nov. 19 1916, that I last saw him alive on Nov 19, 1916, and that death occured on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:

Pneumonitis Following
Adenitis Glands
Neck

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) Adenitis

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) J P Luke M. D.

19..... (Address) Logan

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilford - Idaho | DATE OF BURIAL: Nov 21 1916

20. UNDERTAKER: H D Hagen | ADDRESS: St Anthony

SVMB - YORK CO., PTRS. & BORS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.....

Primary Registration District No.....

File No. 17405

Registered No. .....

County of Fremont

City of St Anthony (No. Industrial School Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eugene T. Mustain

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH.

Don't know (Month) (Day) 1 (Year)

7. AGE

about 33 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (State or Country) Don't know

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (State or Country) Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Friends in F. R. Post.

(Address) St Anthony

15. Filed Oct 15 1916 W Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October (Month) 14 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/11 1916, to 10/14 1916, that I last saw h.im alive on 10/14 1916, and that death occured on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid

unknown (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) –

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Boucher M. D.

10/16 1916 (Address) St Anthony Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 2 days. In the State. 3 yrs.....mos.....days

Where was disease contracted if not at place of death? Dubois

Former or usual residence Dubois

19. PLACE OF BURIAL OR REMOVAL: St Anthony Cemetery — DATE OF BURIAL: Oct 20 1916

20. UNDERTAKER: Lows D. Yager — ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Fremont Primary Registration District No.
City of St Anthony (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 17407
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Bertha Adel Millar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 18th (Day) 1882 (Year)

7. AGE: 34 yrs. 3 mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City Utah

10. NAME OF FATHER: Wm L Flint

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Katie Brown.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W A Millar
(Address): St Anthony

15. Filed Oct 17 1916 W Overall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 15th (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 11th 1916, to Oct 15th 1916, that I last saw h[er] alive on Oct 15th 1916, and that death occurred on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis
Endocarditis Pericarditis

(Duration) 2 yrs. mos. 6 ds.

Contributory (Secondary) Gastro Intestinitis Endocarditis & Nephritis

(Duration) 2 yrs. mos. ds.

(Signed) J R Coby, M. D.
Oct 18 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Parker
DATE OF BURIAL: Oct 17 1916

20. UNDERTAKER: none
ADDRESS: —

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
(No. ....., ... St.)

File No. 17408
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Fremont
City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary M Galloway

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 24 (Day) 1891 (Year)

7. AGE: 25 Yrs. ..... Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Cache Co Utah

10. NAME OF FATHER: Joseph R Shelton

11. BIRTHPLACE OF FATHER (State or Country): Cache Co Utah

12. MAIDEN NAME OF MOTHER: Agnes Murray

13. BIRTHPLACE OF MOTHER (State or Country): Cache Co Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert Galloway
(Address) St Anthony Ida

15. Filed Nov 10 1916 W D Cook Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1916, to Oct 20 1916, that I last saw her alive on Oct 20 1916, and that death occured on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
Puerperal Peritonitis
.....
.....
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Non development of factus
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J Merz Reed M. D.
10-24-1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Teton
DATE OF BURIAL: Oct 22 1916

20. UNDERTAKER: Yager
ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17409

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bessie Barcley Miller

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. (Month) 14 (Day) 1890 (Year)

7. AGE: 26 Yrs. 8 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... at home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Tenn.

10. NAME OF FATHER W. L. Miller

11. BIRTHPLACE OF FATHER (State or Country) Ky.

12. MAIDEN NAME OF MOTHER Mary Barkley

13. BIRTHPLACE OF MOTHER (State or Country) Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. L. Miller

(Address) St Anthony Ida.

15. Filed Nov 10 1916 W D Clerk Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 20" 1916, to Oct 23" 1916, that I last saw her alive on Oct 23" 1916, and that death occured on the date stated above, at 3.30 a. M.

The CAUSE OF DEATH* was as follows: Toxemia from Diabetes Mellitus

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Diabetes Mellitus about

(Duration 5 yrs. ..... mos. ..... ds.

(Signed) M. M. Hawkbaugh M. D.

19..... (Address) St. Anthony Idaho

* State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS [redacted] and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Galliton - Tenn. DATE OF BURIAL: Oct 25 1916

20. UNDERTAKER: Wm D. Yager ADDRESS: St. Anthony

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17411

Registered No. .....

Registration District No. 99

Primary Registration District No. 2177

1. PLACE OF DEATH.

County of Fremont

City of St. Anthony

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmea Swinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 29 (Day) 1899 (Year)

7. AGE: 17 Yrs. 1 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Peter Swinson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Mary Ann Magg

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Peter Swinson
(Address) Twin Falls, Idaho.

15. Filed Dec 12 1916 W D Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
9 (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/6 1916, to 9/22 1916, that I last saw h im alive on 9/21 1916, and that death occured on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 16 ds.
Contributory (Secondary) Frontal sinus infection

(Duration ..... yrs. ..... mos. 16 ds.

(Signed) F. P. Bowley M. D.
19..... (Address) St. Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 16 days. In the State 17 yrs. 1 mos. 0 days
Where was disease contracted if not at place of death? Idaho State Industrial Farm
Former or usual residence Twin Falls Ida

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 9 22 1916

20. UNDERTAKER: W. D. Gagen — ADDRESS: St Anthony Ida

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17413

Registered No. .....

1. PLACE OF DEATH.

County of Fremont

City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Rosina Maag

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. March 19 1842
(Month) (Day) (Year)

7. AGE: 74 Yrs. 6 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Russia

10. NAME OF FATHER: Fred Opp

11. BIRTHPLACE OF FATHER
(State or Country) Germany

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER
(State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Maag
(Address) St. Anthony Idaho

15. Filed Nov 10 1916 W D Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October 1 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 1916, to Oct 1 1916, that I last saw her alive on Oct 1 1916, and that death occured on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Uremia

(Duration) — Yrs. — mos. 10 ds.

Contributory (Secondary) .....
(Duration — yrs. — mos. — ds.

(Signed) John Maag M. D.
Oct 2 1916 (Address) St Anthony, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Anthony, Idaho
DATE OF BURIAL: Oct 3 1916

20. UNDERTAKER: Yager Bros.
ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 99

Primary Registration District No. 2177

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17414

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hilda Welker

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 24 (Day) 1913 (Year)

7. AGE: 3 Yrs. 3 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) St Anthony Ida

10. NAME OF FATHER Jos Welker

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Mamie Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph Welker
(Address) St Anthony Idaho

15. Filed Oct 17 1916 [illegible] Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 16 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1916, to Oct 16 1916, that I last saw h[illegible] alive on Oct 15 1916, and that death occured on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:
Cholera Infantum

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

10/16 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Milford — DATE OF BURIAL: 10/18 1916

20. UNDERTAKER: None — ADDRESS: —

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 77.

Primary Registration District No. 315-6.

File No. 17427

Registered No.

County of Boundary

City of Bonners Ferry Idaho (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Carrie Ulrich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH.

August (Month) ..... (Day) 1860 (Year)

7. AGE: 56 Yrs. 4 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: E. J. Bender

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible] Buchanan

(Address) Bonners Ferry Idaho

15. Filed 12/31/1917. [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December (Month) 28 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Artero-Sclerosis -

(Died on board train)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Spokane, Wash.

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: 1/1 1917

20. UNDERTAKER: J. J. Kaal — ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STEN - YORK CO., PTRS. & ENGS. 24659

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Fremont
City of St Anthony
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. ....., ... St.)

File No. 17439
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carl Porter Featherman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 16th (Day) 1914 (Year)

7. AGE: Two yrs. 7 mos. 15 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Anthony Ida

10. NAME OF FATHER: Raymond Featherman

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Susana Porter

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R Raymond Featherman
(Address) St Anthony

15. Filed Oct 3 1916 A Deerey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 1 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1916, to Oct 1st 1916, that I last saw him alive on Oct 1 1916, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Gastro Enteritis

(Duration) ..... yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J Morfeed M. D.
Oct 3 1916 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Milford Cemetery | DATE OF BURIAL: Oct 3 1916

20. UNDERTAKER: None | ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 17448
Registered No.

1. PLACE OF DEATH.
Registration District No. 99
Primary Registration District No. 2177
County of Fremont County
City of St Anthony (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida M. Koerner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 25 (Day) 1870 (Year)

7. AGE: 26 yrs. 3 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Book Keeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Anthony Koerner

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Elizabeth Holtmier

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. C. Timerding
(Address) St. Anthony. Ida

15. Filed Oct 2 1916 W B Weed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 1" (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22" 1916, to Oct 1" 1916
that I last saw her alive on Oct. 1" 1916
and that death occurred on the date stated above, at 8.45 P.M.

The CAUSE OF DEATH* was as follows:
Septicaemia from abscess of neck.

(Duration) yrs. mos. 10 ds.
Contributory (Secondary) Tonsilitis + inflammatory rheumatism.
(Duration) yrs. mos. ds.

(Signed) M. M. Harshbarger M. D.
19 (Address) St. Anthony Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cincinatti, Ohio
DATE OF BURIAL: Oct. 3 1916

20. UNDERTAKER: Wm D. Yager
ADDRESS: St. Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Heart

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Fremont
City of Parker
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 3177
(No. ....., ... St.)

File No. 17452
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eliza Ellen Barrett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	married

6. DATE OF BIRTH
Dec (Month) 19 (Day) 1834 (Year)

7. AGE
61 yrs. 9 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeping
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Alexander J Chesley

11. BIRTHPLACE OF FATHER (State or Country) Dont know

12. MAIDEN NAME OF MOTHER Elizabeth Davis

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) n a Barrett
(Address) Parker Ida

15.
Filed Oct 10 1916 W D Weaver
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Sept 5 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from not at all 1916, to not at all 1916, that I last saw her alive on had not seen her for some time 1916 and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Mitral Stenosis
.....
.....
(Duration) — yrs. — mos. none ds.
Contributory (Secondary) Cardiac Asthma
(Duration) 20 yrs. mos. ds.

(Signed) J Moorfield M. D.
9/5/ 1916 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Provo Utah
DATE OF BURIAL: Sept 6 1916

20. UNDERTAKER: Wm D. Yager
ADDRESS: St. Anthony Idaho

CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly ment of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Fremont
City of Parker

Registration District No.
Primary Registration District No.
(No. 2 miles So. West of Parker St.)

File No.
Registered No. 17457

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred Stanford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. April (Month) 8 (Day) 1842 (Year)

7. AGE: 74 Yrs. 6 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Thomas Stanford

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Barnett

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. A. C. McFarland
(Address) R.F.D. St. Anthony, Ida.

15.
Filed Nov 10 1916 W. B. Ward
Local Registrar

AMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October (Month) 21 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h— alive on — 191...,
and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
apoplexy

(Duration) 0 Yrs. 0 mos. 0 ds.

Contributory (Secondary) old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [redacted] M. D.
10/24 1916 (Address) St Anthony, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parker Cemetery — DATE OF BURIAL: Oct 25 1916

20. UNDERTAKER: Wm D. Yager — ADDRESS: St Anthony

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17459

Registered No. .....

1. PLACE OF DEATH.

County of Fremont

City of St Anthony

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No 44

Primary Registration District No 5177

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred J. Bloxham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH. Aug (Month) 9 (Day) 1881 (Year)

7. AGE 35 Yrs. 3 Mos. 1 da. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Electrician
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) White Water Wis

10. NAME OF FATHER Geo Bloxham

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Emma Watson

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Edna Bloxham
(Address) St Anthony

15. Filed Nov 11 1916 W Ward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 10 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1916, to Nov 10 1916, that I last saw h alive on Nov 10 1916 and that death occured on the date stated above, at 11P M.

The CAUSE OF DEATH* was as follows:
Mitral insufficiency

(Duration) ..... Yrs. ..... mos. 1½ ds.

Contributory (Secondary) Typhoid

(Duration ..... yrs. 1 mos. 14 ds.

(Signed) A Morfield M. D.

Nov 12 1916 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
White Water Wis.	11/18 1916
20. UNDERTAKER Wm Yager	ADDRESS St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Boise

Registration District No. 15

County of

Primary Registration District No.

File No. 30 1755

City of Roseberry (No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Keziah L. Johnson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.M.	White	Widow

6. DATE OF BIRTH Feb. 22 1835
(Month) (Day) (Year)

7. AGE 81 yrs. 9 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Illinois Vienna Johnson Co.

10. NAME OF FATHER A. J. Kenkendall

11. BIRTHPLACE OF FATHER (State or Country) Illinois Vienna Johnson Co

12. MAIDEN NAME OF MOTHER Cynthia N. Simpson

13. BIRTHPLACE OF MOTHER (State or Country) Illinois Vienna Johnson Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas A Johnson
(Address) Roseberry, Idaho

15.
Filed 5—10 1917 Mary R McDonald Dept Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec. 20 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from DEC 14 1916, to Dec. 20 1916, that I last saw her alive on Dec. 14 1916, and that death occurred on the date stated above, at 9.20 M.

The CAUSE OF DEATH* was as follows:
Senile Gangrene

(Duration) yrs. mos. 6 ds.
Contributory (Secondary) Old age
(Duration) yrs. mos. ds.

(Signed) J S Nagle M. D.
19 . (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State ....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Holmes Cemetary	Dec 24 1916

20. UNDERTAKER	ADDRESS
None	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 22
Primary Registration District No. 2018
(No. ....., ... St.)

File No. 17755
Registered No. .....

1. PLACE OF DEATH.
County of Gooding
City of Wendell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Axford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowered

6. DATE OF BIRTH. May (Month) 25 (Day) 1845 (Year)

7. AGE: 71 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Boilermaker
(b) General nature of industry, business, or establishment in which employed (or employer): R.R. Employee

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Axford

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Bright

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm J. Axford
(Address) Wendell Ida

15. Filed Sept 12 1916 — E. L. Simonton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 12 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10" 1916, to Sept 12 1916, that I last saw him alive on Sept 12" 1916, and that death occured on the date stated above, at 6:20 A. M.

The CAUSE OF DEATH* was as follows:

Cystitis -

..... (Duration) 10 Yrs. — mos. — ds.

Contributory (Secondary) Bronchitis & hypertrophied prostate gland.

~~10~~ (Duration 10 yrs. — mos. — ds.

(Signed) E. L. Simonton M. D.

19.... (Address) E. L. Simonton, MD Wendell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? Salida Col

Former or usual residence Salida Col

19. PLACE OF BURIAL OR REMOVAL: Salida Col — DATE OF BURIAL 191

20. UNDERTAKER: A. E. Thompson — ADDRESS Gooding Ida

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 22

Primary Registration District No. 2018

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17756

Registered No. .....

1. PLACE OF DEATH.

County of Gooding

City of Wendell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Cicero Barton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 4th (Day) 1915 (Year)

7. AGE: 1 Yrs. — Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Burton L. Barton

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Mary A Best

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B Z Barton

(Address) Wendell Ida

15. Filed Sept 28th 1916 E. L. Dinsmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 27 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4th 1916, to Sept 25th 1916; that I last saw him alive on Sept 27th 1916, and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Whooping Cough and Bronchopneumonia

(Duration) — Yrs. 2 mos. 20 ds.

Contributory (Secondary) Bronchopneumonia

(Duration) Yrs. 1 mos. 20 ds.

(Signed) E. L. Dinsmore M.D.

9-27-1916 (Address) Wendell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wendell Idaho

DATE OF BURIAL: Sept 28 1917

20. UNDERTAKER: No Undertaker

ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 17757
Registered No.

1. PLACE OF DEATH.
County of Gooding
City of Wendell
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 22
Primary Registration District No. 2018
(No. ..... St.)

2. FULL NAME No Name

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 19" (Day) 1916 (Year)

7. AGE — Yrs. — Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... ✓
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Gooding Co. Ida

10. NAME OF FATHER Alturas Best.

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Mainie Martin

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alturas Best
(Address) Wendell Ida

15. Filed Sept 22" 1916 F. L. Simonton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 22 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19" 1916, to Sept 21" 1916, that I last saw her alive on Sept 22 1916, and that death occured on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Inanition

✓ (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) ✓ (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F. L. Simonton M. D.
9-22 1916 (Address) Wendell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wendell Ida — DATE OF BURIAL: Sept 22" 1916

20. UNDERTAKER: A. Best — ADDRESS: Wendell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO. PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17842

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 25

County of Payn

Primary Registration District No. 2072

City of Washington School (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Seefried

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb. 8 1870 (Month) (Day) (Year)

7. AGE: 46 Yrs. 8 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): South Russia

10. NAME OF FATHER: John Seefried

11. BIRTHPLACE OF FATHER (State or Country): South Russia

12. MAIDEN NAME OF MOTHER: Louisa Kutsche

13. BIRTHPLACE OF MOTHER (State or Country): South Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emanuel Seefried

(Address) Aberdeen, Idaho

15. Filed Nov 26 1916 R F Nold Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 22 1916 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

No physician in attendance

Walking for last days

Probably Apoplexy

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lutheran Cemetery Twin Falls Idaho

DATE OF BURIAL: Nov 24 1916

20. UNDERTAKER: Nona

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & ENGS. 24659

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 18250
Registered No. 18

1. PLACE OF DEATH.
County of Bannock
City of Chesterfield
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Gustaveson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
May (Month) 6 (Day) 1910 (Year)

7. AGE
5 Yrs. 9 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Utah

10. NAME OF FATHER Carl R. Gustaveson

11. BIRTHPLACE OF FATHER
(State or Country) Sweden

12. MAIDEN NAME OF MOTHER Lucina Parsons

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Carl Gustaveson
(Address) Chesterfield

15.
Filed 6/24 1917
D. J. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from no attendance 191...,
that I last saw h... alive on ... 191...,
and that death occured on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
sudden
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) D. J. Smith M. D.
6/24 1917 (Address) Bancroft

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chesterfield — DATE OF BURIAL: 2/15 1916

20. UNDERTAKER — ADDRESS

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 93

Primary Registration District No. 2371

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 18346

Registered No. .....

1. PLACE OF DEATH.

County of Nez Perce

City of Peck

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel D Boyd.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept. (Month) 14 (Day) 1832 (Year)

7. AGE 84 Yrs. 1 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Merchant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Somerset Co. Pa.

10. NAME OF FATHER Douglas Boyd

11. BIRTHPLACE OF FATHER Belfast Irdland (State or Country)

12. MAIDEN NAME OF MOTHER Susan Lichty

13. BIRTHPLACE OF MOTHER Maryland (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Myrtle Washburn
(Address) Peck Idaho

15. Filed 10-30 1917

J M. Tyler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 30 (Month) (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1916, to Oct. 30 1916, that I last saw him alive on Oct. 30 1916, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Septicemia of hand

(Duration) Yrs. 1 mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M. Tyler M. D.

10-29-17 (Address) Peck

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Peck

DATE OF BURIAL 10-1 1917

20. UNDERTAKER None.

ADDRESS

SYMS - YORK CO., PTRS. & BOOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
Registration District No. 93
Primary Registration District No. 2371
(No. ..... St.)
File No. 18347
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Coral L. Mayo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Sept (Month) 17 (Day) 1895 (Year)
7. AGE: 21 Yrs. 3 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): Minn
10. NAME OF FATHER: Geo Mayberry
11. BIRTHPLACE OF FATHER (State or Country): ✓
12. MAIDEN NAME OF MOTHER: Julia Shaw
13. BIRTHPLACE OF MOTHER (State or Country): Iowa
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Mayo
(Address) Peck Idaho
15. Filed 12-30 1917
J. M. Tyler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 29 (Day) 1916 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1916, to Dec. 29 1916,
that I last saw her alive on Dec 29 1916,
and that death occured on the date stated above, at 6 a M.
The CAUSE OF DEATH* was as follows: Pulmonary hemorrhage
(Duration) Yrs. mos. 1 ds.
Contributory (Secondary) Lobar Pneumonia
Chronic abscess of lung
(Duration) yrs. 6 mos. ds.
(Signed) J. M. Tyler M. D.
12-30 1917 (Address) Peck Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 12-31 1916
20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 18434
Registered No. 955

Registration District No. 78
Primary Registration District No. 2155
(No. ..... St.)

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gordon T. Wilkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH.
July (Month) 20 (Day) 1902 (Year)

7. AGE
14 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Student
(b) General nature of industry, business, or establishment in which employed (or employer)... Grade School

9. BIRTHPLACE
(State or Country) Minn.

10. NAME OF FATHER
L. D. Wilkins

11. BIRTHPLACE OF FATHER
(State or Country) Wis.

12. MAIDEN NAME OF MOTHER
Emma Stanley

13. BIRTHPLACE OF MOTHER
(State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. D. Wilkins
(Address) Sandpoint

15.
Filed Mar 9 1917
M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 30 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1916, to Dec 30 1916, that I last saw him alive on Dec 30 1916, and that death occured on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Grip
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. McKinnon M. D.
19..... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho — DATE OF BURIAL: Jan 2 1917

20. UNDERTAKER: C. M. Brookes — ADDRESS: S. P.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
(No. ....., ... St.)

File No. 18539
Registered No. 56

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agusta Palmgren

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 17 (Day) 1916 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Carl T Palmgren

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Salaena Chury

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs C.T. Palmgren
(Address) Blackfoot Idaho

15. Filed Mch 8 1917 M.E. Price Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 17 (Day) 191[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairview cemetery — DATE OF BURIAL: 3-9 1917

20. UNDERTAKER: E J Funk — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of [redacted] Custer

City of [redacted] Challis

Registration District No. 105

Primary Registration District No. 2185

(No. ....., ... St.)

File No. 18601

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Trefz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.

Unknown (Month) (Day) 1 (Year)

7. AGE

85 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE

(State or Country) Maine

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER

(State or Country) "

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) K. D. Williams

(Address) Local Registrar Challis Idaho

15.

Filed Nov 29th 1916

K. D. Williams
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH on

Nov 26 1916

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Old age and General debility

No Physician in attendance

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Challis	Nov 28th 1916
20. UNDERTAKER	ADDRESS
K. D. Williams	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTGS. & ENGS. 24658

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 18613
Registered No. 7

1. PLACE OF DEATH. Registration District No. 47
County of Lewis Primary Registration District No. 2124
City of Nezperce (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Edna A Doggett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH Oct (Month) 5 (Day) 187X (Year)

7. AGE 42 yrs. 1 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Arkgrove, Mitt

10. NAME OF FATHER William A. Woodward

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Sarah Vanvoither

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) S J Doggett

15. Filed 8/31/ 191 7 J. P. Roberts Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec (Month) 1 (Day) 191 6 (Year)

17. I HEREBY CERTIFY, That I attended deceased from arrived 191..., to half hour 191...
that I last saw him alive on after death 191 6
and that death occurred on the date stated above, at dead on arrival 2:00 A.M.

The CAUSE OF DEATH* was as follows:
Acute Angina Pectoris

..... (Duration) one hour yrs. ..... mos. ..... ds.
Contributory (Secondary) none
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. T. Rawley M. D.
..... 19..... (Address) Nezperce

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Nezperce Idy | DATE OF BURIAL ..... 191...

20. UNDERTAKER L. O. Donovan | ADDRESS Nezperce

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS-YORK CO., PRINTERS & BINDERS. BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 19318
Registered No. 21

1. PLACE OF DEATH.
County of Lemhi
City of Pierce Creek (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cornelious L. McSherry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) 1 (Day) ..... (Year)

7. AGE ..... Yrs. 66 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Brick Mason
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Peter McSherry

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Ann Murphy

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank M. McSherry
(Address) 238 Grand View Ave San Francisco Cal

15. Filed Nov. 15 1917 E. D. Henderson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
About December 13th 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:
Exposure
(Found in the snow in spring)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) William C Doebler M. D.
1917 (Address) Salmon Ida County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery
DATE OF BURIAL: 4-30 1917

20. UNDERTAKER: W. C. Doebler
ADDRESS: Salmon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

Jan-13.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. Ada

File No. 20388

Registered No. 10

1. PLACE OF DEATH.

County of Ada

City of Near Boise (No. Near Boise St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elmer E. Shoemaker

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct 31 (Month) (Day) 1907 (Year)

7. AGE: 7 Yrs. 2 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: C. G. Shoemaker

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Lillie I. Edwards

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. G. Shoemaker
(Address) Boise Idaho

15. Filed March 5 1918 L. P. Gemmer Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 30 (Day) 191 8 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased from Mar 4 191 8, ~~to~~ 191 , ~~that I last saw him alive on~~ 191 and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Drowned in Boise River
Fell in Jan. 30 16
Remains found Mar. 4 1918

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner Ada Co. M. D.

3/5 19 18 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Mar 6 1918

20. UNDERTAKER: Fry & Summers — ADDRESS: Boise Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 22803.
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bonner
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 81
Primary Registration District No. .....
(No. ....., ... St.)

2. FULL NAME John Eastlund

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1873 (Year)

7. AGE
45 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: not given
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Sweden

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER
(State or Country) unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER
(State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. M. Knapp
(Address) .....

15.
Filed Oct. 29 1918 R. D. Hanson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 13 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191..
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at ....., ...M.

The CAUSE OF DEATH* was as follows:
Gunshot wound,
Suicide
.....
.....
.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) W. M. Knapp M. D.
.....19.... (Address) Coroner

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL, OR REMOVAL: Priest River Cemetery ..... DATE OF BURIAL 1916.

20. UNDERTAKER: J. E. Priest ADDRESS Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

36289

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 26289

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

County of Idaho

City of White Bird (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Bentz

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April (Month) 13 (Day) 1844 (Year)

7. AGE: 71 yrs. 11 mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Bentz
(Address) White Bird

15.
Filed Dec 28 1916 W. A. Foskett
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar (Month) – 20 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1916, to Mar 20 1916, that I last saw him alive on Mar 20 1916 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation

(Duration) 3 yrs. mos. ds.
Contributory (Secondary) Chronic Nephritis
(Duration) 2 yrs. mos. ds.

(Signed) W. A. Fosketto M. D.
19 (Address) White Bird

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL: Mar 22 1916

20. UNDERTAKER: Hancock | ADDRESS: Grangeville

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 55502
Registered No. 22

1. PLACE OF DEATH
County of Bonneville
City of Soda Springs
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 82
Primary Registration District No. 2137
No. ..... St.)

2. FULL NAME Ernest Lund

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JUN 4 BUREAU OF VITAL STATISTICS

JUN 28 1926

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, ~~MARRIED, WIDOWED OR~~ DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept (Month) ..... 1 (Day) ..... (Year)

7. AGE about 40 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eric Kaeck Log
(Address) Soda Springs Idaho

15. Filed May 27 1926 Eric Kaeck Log Local Registrar.

MEDICAL CERTIFICATE OF DEATH 45

16. DATE OF DEATH
May 27 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1926 to May 27 1926 that I last saw h..... alive on May 27 1926 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Cancer of Sigmoid

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Eric Kaeck Log M. D.
May 27 1926 (Address) Soda Springs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

RECEIVED JUN 3 1926

19. PLACE OF BURIAL OR REMOVAL Soda Springs, Ida. DATE OF BURIAL May 28 1926

20. UNDERTAKER E J Wilcox ADDRESS Soda Springs

RECEIVED OCT 20 1926

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

55039

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 55039
Registered No. 105

1. PLACE OF DEATH.
County of Shoshone
City of Mullan
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. ....., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alrich J. Grills

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 3 (Day) 1876 (Year)

7. AGE: 88 yrs. 10 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Night Policeman
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: no Information

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Ward
(Address) Wallace Idg

15.
Filed Sept 30, 1926 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 31 (Day) 1926 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1915, to Jan 31 1926
that I last saw h[illegible] alive on Jan 31 1926
and that death occurred on the date stated above, at 6.45 a M.

The CAUSE OF DEATH* was as follows:

Chr. Int. Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Chr. Myocarditis

(Duration) 2 yrs. mos. ds.

(Signed) James R Dean M. D.
9/25 1926 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL: Mullan Idaho | DATE OF BURIAL: Feb 3rd 1926

20. UNDERTAKER: Ward Undrg Co | ADDRESS: Wallace Idg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED OCT 6 1930

7 1910

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7 1 9 1 0

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 190
Primary Registration District No. 2178
(No. 149)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Winnie Floyd.

(a) Residence. No. Salem St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	M

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Oliver Floyd.

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	11	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS

10. NAME OF FATHER Joseph Clark.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Laura Larson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Oliver Floyd.
(Address) Salem Idaho

15. Filed 10/4, 1930 J. P. Morris Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 23 (Day) 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Shock.

(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Child Birth
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. R. Shupe, M. D.
....., 19..... (Address) Sugar City

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Charles Utah	12/24 1916
20. Undertaker	Address
John O. Philips	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

129773 129773

United States
Department of Commerce
Bureau of the Census

CERTIFICATE OF DEATH
STATE OF IDAHO

State File No.
Local Reg. No.
Reg. Dist. No.

1. **PLACE OF DEATH:**
(a) County Shoshone
(b) City or town Kellogg Idaho
(c) Street Address or R. F. D. No.
(d) Death Occurred Inside? X Outside? city or town
(e) Died in a Home Hospital Institution Other place
(f) Name Hosp. or Inst. Stayed days
(g) Lived in this county 2 years months days
Note. For a person residing in THIS county LESS than 1 year, give FORMER residence under item 2.

2. **USUAL RESIDENCE OF DECEASED:** (Always fill in these)
(a) State (b) County
(c) City or town
(d) Street Address or R. F. D. No.
(e) Deceased lived Inside? Outside? city or town
(f) If foreign born, in U. S. yrs. Citizen of U. S.?
(g) How long had deceased lived in Idaho? years
(h) Former residence (city, state)

3. (a) **FULL NAME** CHARLES ARTHUR BUNNELL

3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Irma
6 (c) Age of husband or wife if alive years
7. Date of Birth (Month, Day, Year) February 24, 1868

8. AGE	Years	Months	Days	If less than 1 day
	48	8	18	hrs min.

9. Exact Occupation Painter — Did this work for 23 yrs.
10. Industry or Business B-H & S Co — Date last worked Nov 11, 1916
11. Birthplace (City or town) Canada (State or foreign country)

Father
12. Name Chas. Arthur Bunnell
13. Birthplace (City or town) New York (State or foreign country)

Mother
14. Maiden name No my
15. Birthplace (City or town) New York (State or foreign country)

16. Informant's **OWN** Signature and Address Irma Mae Bunnell Kellogg Idaho
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place:
18. Funeral Director's **OWN** Signature and Address M. C. Thornhill Kellogg Idaho
19. (a) (Date received and filed) (b) Geo. Teeter (Registrar's signature)

MEDICAL CERTIFICATE OF DEATH

20. **DATE OF DEATH** (Month, Day, Year) Nov. 11, 1916
at o'clock M.

21. **I HEREBY CERTIFY,** That I attended deceased from 19, to 19
I last saw h. alive on 19; death is said to have occurred on the date and hour stated above.

Immediate Cause of Death: Fract Skull — Duration 20 Min
Due to Fall in Mine
Due to
Other conditions
(Include pregnancy within 3 months of death)

Where was disease first contracted?
Name of operation Date
Major finding
Finding of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to **EXTERNAL CAUSES,** also fill in the following: Accident? Suicide? Homicide?
Occurred 19 City, county, state
where violence occurred
Place of Violence: Home Farm Industry
Public Place While at work
Means of injury

23. Attendant's **OWN** Signature
and Address (Official position) Date 19
(For additional space, use reverse side)

Informant, Funeral Director, Registrar and Medical Attendant, EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215). Address correspondence to State Bureau of Vital Statistics, Boise, Idaho.